State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
TITLE V MCH BLOCK GRANT APPLICATION

I. COMMON REQUIREMENTS FOR APPLICATION AND ANNUAL REPORT

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1.4 Overview of the State

The Title V program in Michigan operates within the larger context of public health services as articulated in the Department of Community Health's mission statement: "...to promote access to the broadest possible range of quality services and supports; take steps to prevent disease, promote wellness and improve quality of life; and strive for the delivery of those services and supports in a fiscally prudent manner." To accomplish this mission, the department employs a variety of resources including federal, state and local funding to provide, arrange or assure access to a broad range of health and other social services. Services are arranged and delivered at the community level, employing local health departments and local collaborative bodies to determine the needs of their community and the best system for addressing those needs. Services are delivered through a variety of public and private agencies, including local health departments, hospitals, clinics, private practices, schools, Planned Parenthood organizations, migrant health centers, and primary care centers. Cooperative efforts to achieve specific initiatives are arranged with the private sector, such as managed care plans, universities, Delta Dental of Michigan, Blue Cross/Blue Shield of Michigan, Michigan State Medical Society, and Michigan Association of Broadcasters, as well as with other state departments. Within the Department of Community Health, Title V programs and planning and policy activities are coordinated with the Medicaid program, MIChild (state CHIP), mental health and substance abuse services, chronic disease programs, communicable disease programs, WIC, and injury prevention programs.

The public health functions of assessment and assurance are shared with local health departments (LHD). Under the Public Health Code, all counties are required to provide for a local health department and are charged with: prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable populations; development of health care facilities and services delivery systems; and regulation of health care facilities and services delivery systems to the extent provided by law. There are 30 single county health departments, 14 district health departments covering multiple counties, and one city health department. See Section 1.5.2 for further discussion of the role of local health departments.

According to the 1990 U.S. Census, 70.5% of the state's population resides in urban areas. However, only 25 of the state's 83 counties are classified as Metropolitan Statistical Counties. All specialized health care facilities are located only in urban areas, making it difficult for rural residents to access those facilities. Rural road conditions when it rains or snows heavily also creates barriers to accessing care, particularly in the Upper Peninsula. Another access problem is created by the fact that the sole ground connection between the Upper and Lower Peninsulas is via the Mackinac Bridge, which may be closed during windy, foggy and icy conditions.

Language is another potential barrier to access to care. An estimated 2.2% of persons age 5 and over do not speak English "very well". Of these, 46,144 speak Spanish, 28,229 speak an Asian or Pacific Island language, and 114,289 speak other languages.

Also, according to the 1990 Census, there were 251,687 families, or 10.2% of all families, who were below the 100% poverty level. Of related children under 18 years of age, 18.6% lived in poverty. 22.1% of related children under 5 years were below poverty. Among the white population, 12.4% of children under 18 and 14.8% of children under 5 were below the poverty level. For black children under 18, 46.2% were below the poverty level, while 32.5% of American Indian, Eskimo and Aleut and 14.6% of Asian/Pacific Islander children under 18 were below poverty. For children under 5, 53.5% of blacks, 40.5% of American Indian, Eskimo and Aleut, and 15.4% of Asian/Pacific Islanders were below poverty.

In 1998, the total estimated population in Michigan was 9,817,244, according to the Michigan Information Center. These include 134,483 infants, 2,671,110 children between the ages of 1 and 20 years, and 2,205,426 women of childbearing age (15-44 years). Approximately 79% of infants were white, 18% were black, 2% were Asian and Pacific Islander, and less than 1% were American Indian. Of Michigan residents aged 1-20 years, 80% were white, 18% were black, 1.6% were Asian/Pacific Islander, and 0.8% were American Indian. Among women of childbearing age, 82% were white, 16% were black, 1.7% were Asian/Pacific Islander, and 0.8% were American Indian.

According to the Division for Vital Records and Health Statistics, MDCH, the ten leading causes of death in 1998 for Michigan were: heart disease; cancer; cerebrovascular diseases; chronic obstructive pulmonary diseases; unintentional injuries; pneumonia and influenza; diabetes

mellitus; kidney disease; chronic liver disease and cirrhosis; and suicide. Mortality rate disparities between black male and white male population increased during the last 28 years. Michigan age-adjusted mortality rates for black males were 43% higher than their white counterparts in 1970. By 1998, the mortality rate for black males were 63% higher than that for their white counterparts. Steady declines have generally occurred since 1970 both in Michigan and in the United States in age-adjusted rates in each race-sex group. From 1970 to 1998, the age-adjusted mortality rates for black males and females declined 28% and 33%, respectively. During this period the age-adjusted national mortality rates for black males and females declined by 31% and 34%, respectively. In comparison, the Michigan mortality rates for white males and females declined 36% and 28%, while the national rates dropped 36% and 29%, respectively. For Michigan children under 1 year of age, the leading cause of death in 1998 was conditions originated in the perinatal period. For Michigan children 1 year of age or over, the leading cause of death in 1998 was unintentional injuries.

In 1998, the latest year for which data are available, 133,649 live births occurred to Michigan resident women. Between 1990 and 1998, the number of live births declined by 13 percent. The racial composition of women having live births in Michigan changed during 1978 to 1998. The proportion of all live births born to white women declined from 82.6% in 1978 to 78.7% in 1998. The proportion of all live births born to minority women increased from 17.4% to 21.3% during the same time period. The fertility rate (per 1000 women) for women aged 15-17 years declined from 30.8 in 1995 to 25.4 in 1998. Although 65% of the births to teens are to white mothers, only about one in ten births to white women were born to women under the age of 20 years. Among Asian/Pacific Islander women and women of Arab ancestry, about one in 21 and one in 13 live births, respectively, occurred to women under 20 years of age. On the other hand, among black, American Indian women and women of Hispanic ancestry, approximately one in five live births occurred to women under the age of 20 years.

Implementation of the statewide Medicaid managed care program and MIChild program (CHIP) are the top priorities of the Department. 1999 was the first full year of statewide operation of the Medicaid managed care program. The Title V MCH program works with the Medical Services Administration to develop/refine quality assurance standards, monitoring requirements and service delivery requirements/guidelines for the managed care plans. The Title V MCH program monitors the health status of the MCH population and identifies issues of access to and quality of

services, including those issues resulting from implementation of welfare reform.

The state's Child Health Insurance Program (CHIP), MIChild, was implemented in 1998. The Title V MCH program participated in development of outreach plans and materials and in training of local agencies on the program and application process. As of April 1, 2000, 12,388 children were enrolled in MIChild.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The Michigan Department of Community Health is the state health agency, responsible directly to the Governor. In 1997, a major reorganization of state departments combined the former departments of Public Health, Mental Health, Medical Services Administration (Medicaid) and Office of Services to the Aging. The new department was organized into "administrations." (See organization charts in Section 5.3) The Community Living, Children and Families (CLCF) Administration included MCH programs, children's mental health services, WIC and residential programs for persons with mental illness or developmental disabilities. The director of the CLCF Administration is the state Title V Director. In 1999, the WIC program was separated from CLCF and established as a separate administration reporting to the department director. The Medical Services Administration includes Children's Special Health Care Services.

The CLCF Administration is organized into the Division of Family and Community Health, the Division of Mental Health Services to Children and Families, the Division of Program Administration and Consumer Resources, the Office of Multi-Cultural Services, the African American Male Health Initiative, and the Self-Determination Initiative. The Division of Family and Community Health administers most of the MCH programs, including: Adolescent Health, the Michigan Abstinence Partnership, Oral Health, Family Planning, Hearing and Vision Screening for pre- and school-age children, Newborn Hearing Screening, Childhood Lead Poisoning Prevention, Fetal-Infant Mortality Review,

Maternal and Child HIV/AIDS, Maternal and Infant Health Advocacy Services, Prenatal Smoking Cessation, and SIDS. The division also maintains a liaison with the state's immunization program, administered by the Public Health Administration, and participates in inter- and intra-agency initiatives, such Part C of IDEA and the Child Death Review Program. In addition, the division participates in quality assurance and issue identification activities concerning Medicaid-funded MCH services, including EPSDT, and Maternal and Infant Support Services.

The Division of Program Administration and Consumer Resources administers the Newborn Screening and Hereditary Disorders Program, in addition to the Office of Specialized Nursing Homes/OBRA Program, and housing programs and residential contracts for persons with mental illness or developmental disabilities.

The Medical Services Administration (MSA) administers the state's Medicaid program, Children's Special Health Care Services, and the state's Child Health Insurance Program, MIChild. The Children's Special Health Care Services Plan Division is part of the Plan Administration Bureau in MSA.

The primary authority for maternal and child health programs in the state is the Public Health Code (P.A. 368 of 1978, as amended). Part 23 of the Code requires the Department to identify priority health problems and develop a list of basic health services to be made available and accessible to all residents in need of the services without regard to place of residence, marital status, sex, age, race, or inability to pay. The current list of designated basic health services is: immunizations, communicable and sexually transmitted disease control, tuberculosis control, prevention of gonorrhea eye infection in newborns, newborn screening for seven conditions, health/medical annex of the emergency preparedness plan, and prenatal care. Part 24 of the Code spells out the authority and responsibility of local health departments. Section 5431 requires screening of newborns for PKU, galactosemia, hypothyroidism, maple syrup urine disease, biotinidase deficiency, sickle cell anemia, "and other treatable but otherwise handicapping conditions as designated by the department." Screening for congenital adrenal hyperplasia was designated as a required test in 1993.

Part 58 of the Code authorizes the department to establish and administer a program of services for children with special health care needs. Section 9101 requires the department to establish a plan for school health services in cooperation with the Department of Education. Section 9131 requires the department to publicize places where family planning services are available. Part 92 authorizes and sets certain requirements for immunization. Part 93 establishes a program of hearing and vision screening for children.

P.A. 167 was passed by the Michigan Legislature in 1997 which supported statewide development of child death review teams. The law also defined the composition of the teams, established reporting requirements, provided for training and technical assistance and exempted team meetings from FOIA.

1.5.1.2 Program Capacity

Most programs are operated by local health departments, qualified health plan (managed care) providers, hospitals and other community health care providers. The department contracts with these agencies to provide services based upon needs identified at the state or local level, utilizing a combination of state funds, Title V, Medicaid and fees. All but a small portion of the federal Title V funds are allocated to local agencies for the provision of MCH services.

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

Services for pregnant women, mothers and infants are supported and operated in conjunction with other funding sources, primarily Medicaid. Michigan has taken advantage of changes in federal Medicaid rules by expanding eligibility for pregnant women and infants up to 185% of FPL.

The Newborn Screening Program screens for seven disorders: PKU, galactosemia, hypothyroidism, MSUD, biotinidase deficiency, sickle cell anemia, and congenital adrenal hyperplasia. Blood samples are submitted by hospitals to the state laboratory which analyzes the samples and reports the results to the Newborn

Screening Program. Program staff follows up on all positive or unsatisfactory test results. In 1999, 131,455 newborns were screened for all seven conditions.

The Hereditary Disorders Program coordinates statewide services for genetic diagnosis and counseling, and provides information about birth defects and inherited diseases. Six regional coordinating centers are funded to provide a network of clinics for diagnosis, counseling and medical management, and to provide outreach education to community groups, including families, health professionals and teachers. In FY '99, 2,288 families received diagnosis and counseling services at the regional centers.

The Family Planning Program makes available general reproductive health assessment, comprehensive contraceptive services, related health education and counseling, and referrals as needed to Michigan residents. Services are available to anyone, but the primary target population is low-income women and men. Services are delivered through local health departments, planned parenthood affiliates, hospitals and private non-profit agencies. In 1999, 162,254 women and 4,639 men were served.

The Fetal-Infant Mortality Review Program is supported by a three-year grant to establish a state level FIMR and to support efforts to build FIMR capacity in local communities. The program provides technical assistance, consultation, and support to established FIMR programs and provides professional interagency training for communities participating in FIMR projects. Currently, five teams are operating in Kalamazoo, Saginaw, Genesee, Crawford and Lake-Oceana-Newaygo counties.

Infant Support Services, funded by Medicaid, provide non-medical support services consisting of health education, parenting education, breast-feeding education, counseling in appropriate infant care, nutrition, social casework, infant mental health, transportation, care coordination, referral and follow-up. Services are targeted to high risk Medicaid-eligible infants and their families. Infants are referred by primary care providers when one or more of the following risk factors is present: abuse of alcohol or drugs or smoking; mother is under the age of 18 and has no family

support; family history of child abuse/neglect; low birth weight; mother with cognitive, emotional or mental impairment; homeless or dangerous living situation; or any other condition that may place the infant at risk of death, significant impairment or illness. Services are provided by a team of professionals including a nurse, nutritionist and social worker. An infant mental health specialist is an optional member of the team. In FY 1999, 5,018 new clients were enrolled in the program through the fee for service program.

The Maternal Support Services Program provides nutrition, psychosocial, nursing and transportation services to Medicaid-eligible, high-risk pregnant women referred by a prenatal care provider. The high-risk factors are: unstable or non-existent social support systems; history of child abuse/neglect; negative feelings/attitudes toward the pregnancy; unstable emotional status/inability to cope; educational/developmental deficits; dysfunctional family/domestic violence; and nutritional deficits. In FY 1999, 8,576 women received services reported through the fee-for-service program.

The Maternal and Child HIV/AIDS Program assures that coordination of existing medical care and social support services exists for families living with HIV/AIDS in southeast Michigan. The program follows a family-centered approach to service delivery, employing a family case manager to link families with needed care across service systems. The target populations are women, adolescents, children and families with HIV, and sexually-active women and youth. Clients receiving services from contracted agencies have access to primary and tertiary care for HIV disease and may also receive the following services: comprehensive, coordinated, family-centered care and case management services; access to an emergency fund for eligible expenses; gynecological services; psychosocial services; information and access to available clinical trial participation; opportunities to participate in a community advisory board; child care resources; transportation; resources to enhance development of leadership skills in women and/or adolescents affected by HIV; and health education, information and referrals for other health and psychosocial services. 845 clients were served in calendar year 1999.

Maternal and Infant Health Advocacy Services is designed to outreach to pregnant women who are not in prenatal care, assist high-risk women in dealing with situations which may keep them from remaining in prenatal care, and support and reinforce the health education messages delivered by professionals. MIHAS activities are delivered by a team of paraprofessional advocates and a supervisor specifically trained to deal with the psychosocial problems of high-risk, low-income pregnant women. Twenty-two teams operate in 16 counties, including those counties with the highest infant mortality rates in the state. Services include: case-finding; making and confirming prenatal care and other health service appointments; providing information and referrals to other needed services; arranging transportation to health care providers and other service agencies; reinforcing education provided by professionals regarding pregnancy, childbirth, parenting, breastfeeding and infant care skills; completing a risk screening assessment; educating and motivating clients to keep health care appointments and to comply with health care advice; assessing unmet need for family planning, well-child or psychosocial services; and providing information regarding procedures to follow for social and medical emergencies.

The Newborn Hearing Screening Program is a hospital-based, voluntary program to screen newborns for hearing loss by one month of age, assure diagnosis by the age of three months, and, when appropriate, assure intervention services by the age of six months. The department provides education to local health care facilities on the importance of newborn hearing screening, the need for a collaborative local team for infants requiring follow-up, and maintains a statewide database for tracking screening and follow-up activities. As of March, 2000, 64 hospitals are participating in the screening program, serving 86,720 newborns (approximately 65% of annual estimated live births). Additional hospitals have indicated interest in beginning the screening this year.

The Prenatal Smoking Cessation Program works with low-income pregnant smokers who are receiving health services in public prenatal programs. The intervention model is a one-on-one counseling consisting of four steps: assess and document status and stage of readiness to quit; provide at least one intervention message geared to the identified stage; help client set a goal; and provide praise,

encouragement and aids for quitting.

The Sudden Infant Death Program seeks to inform the public about measures to reduce the risk of sudden infant death, to support families who have experienced a death, and to assure the accurate and timely surveillance of sudden infant death in Michigan. Michigan is actively promoting the Back to Sleep national campaign to change infant sleep position from tummy to back, which has proven to reduce the risk of Sudden Infant Death Syndrome (SIDS). Information is also being disseminated on other risks, such as smoking prenatally, second hand smoke, overheating, suffocation risk of soft bedding and toys, and allowing infants to sleep with adults and other older children. A campaign has been launched in Southeast Michigan by the Michigan SIDS Alliance and Children's Hospital of Michigan to inform the public through billboards, bus boards, brochures, radio, television, and speakers. The SIDS Alliance maintains a toll-free number for public information and referral. Risk reduction education and family support services are provided by local health departments, the Michigan SIDS Alliance peer providers, and Renaissance Home Health Care for residents of Wayne County. Bereavement counseling includes an initial telephone contact soon after the baby's death to offer assistance and information about SIDS. Up to three home visits may be reimbursed for family members or other significant parties, such as day care providers. The focus is on dealing with grief and loss and understanding the unique aspects of SIDS.

Preventive and Primary Care Services for Children

The Michigan Abstinence Partnership is a broad-based group with members from across the state, including health professionals, parents, teens, educators, and representatives from business, government, volunteer organizations, and advocacy groups. The partnership aims to positively impact adolescent health problems through promoting abstinence from sexual activity and the related risky behaviors such as the use of alcohol, tobacco, and other drugs. A comprehensive approach targeting 9 to 17 year old children and their parents is used and includes coalition development, community activities, media, and educational and promotional items. Educational materials promote the abstinence message and efforts of the

partnership. The media campaign has been developed targeting 9 to 17 year old children through television, radio, and posters. Promotional items such as buttons and t-shirts are also being utilized. A team of technical assistants is in place to assist the communities in local partnership activities and coalition building.

The Adolescent Health Program includes two models of service delivery -- adolescent health centers and alternative models. The adolescent health center model provides on-site primary health care, psychosocial, health promotion and disease prevention education, and referral services. The alternative model focuses on case finding, screening, referral for primary care, and providing health education services. The Program administers 20 adolescent health centers and eight alternative health delivery sites which are located in 16 counties across the state. In 1999, the adolescent health centers served 20,004 unduplicated users, during 51,914 visits, and provided 76,798 services and 5,479 referrals. The alternative models provided 8,557 services, 1,125 referrals, and conducted 3,597 health education sessions with 61,133 participants.

The Oral Health Program provides consultation, technical assistance, and statewide coordination for oral health programs to local health departments and other community agencies. Forty-six local agencies, including local health departments, primary care centers, migrant health clinics, and Indian Health Services (IHS) conduct public health dental programs. Forty-three provide direct clinical services and three programs refer to private dental offices. One local health department program is supported by funding from the MCH block grant to provide dental care to dentally underserved children in a five county area. Other programs are funded locally, through fee-for-service collection, Medicaid, private foundation funds, and federal funding (IHS, primary care, and migrant health). A network of volunteer dentists provides dental care to persons who are mentally and physically handicapped, who are medically compromised, or who are elderly, through the Donated Dental Services Program, supported by the Healthy Michigan Fund. The department provides dental services to the developmentally disabled population who are not eligible for Medicaid, cannot access a Medicaid provider, do not have other dental coverage, and cannot afford dental care. Services provided are limited to the

treatment of those conditions which would lead to generalized disease due to infection or improper nutrition.

The Hearing Screening Program supports local health department screening of children at least once between the ages of three and five years and every other year between the ages of five and 12 years, to prevent permanent hearing impairment by providing appropriate treatment. A few local health departments also screen children who are younger than age three using a subjective behavioral technique which rules out a severe profound hearing loss. Local health department staff are trained as either an EPSDT technician or a comprehensively trained school screening technician. Quality assurance is provided for the approximately 200 local health department threshold technicians by the MDCH audiology consultant, through field visits and required biennial skills update workshops. The Hearing Program screens in excess of 680,000 children per year in preschool and school programs.

The Division of Family and Community Health (DFCH) has worked for a number of years to promote timely vaccination of Michigan's children, and has identified an individual to serve as a liaison to the Community Public Health Administration's Division of Immunization which is responsible for the state's immunization efforts. The liaison: works with maternal and child health programs including Women, Infants and Children (WIC) program; Maternal/Infant Support Services; teen health centers; and interagency programs providing services to children to integrate immunization assessment, referral, and/or administration of vaccines; works with the Immunization Division Special Populations Coordinator to improve immunization and assessment of migrant children; collaborates with the Immunization Division and other interested organizations and agencies on the development of health care provider education materials; and collaborates with the Immunization Division and other interested organizations and agencies on outreach and education efforts to parents and the public.

The Childhood Lead Poisoning Prevention Program (CLPPP) is funded by a grant from the Centers for Disease Control and Prevention (CDC) which supports the coordination of lead poisoning prevention and surveillance services for children in

Michigan, and the funding of pilot sites for primary prevention of lead poisoning through the identification of lead hazards in housing. Infants, children under six years, and pregnant women are priorities for screening and testing. Program service components are education and outreach, blood screening and testing, tracking, reporting, primary prevention activities, policy development and program management, quality assurance, and evaluation. In 1999, 90,078 children were screened and 6,169 with elevated blood lead levels at or above 10 mg/dl were referred for follow-up diagnosis and treatment services.

Vision screening of pre-school children is conducted by local health department staff at least once between the ages of three and five years, and school-age children are screened in grades 1, 3, 5, 7, 9, 11, or in grades 1, 3, 5, 7, and in conjunction with driver training classes. The battery of vision screening tests is administered by local health department staff who have been trained by the Vision Consultant in the Division of Family and Community at MDCH. Quality assurance is provided for approximately 200 local health department school screening technicians by the MDCH Vision Consultant and a cadre of specially trained individuals, through field visits and skills update workshops provided yearly in at least three regional sites. Consultation is also provided to Vision Program Coordinators in all local health departments. All county or district health departments have a Vision Screening Program which includes initial screening, retesting, and referral of children. In addition, follow-up for all screening is required which assures that care is received. The Vision Screening Program screens more than 850,000 preschool and school-age children in Michigan each year. More than 70,000 referrals are made to eye doctors annually.

Services for Children with Special Health Care Needs

The CSHCN Program in Michigan is known as "Children's Special Health Care Services". A variety of program components support core public health functions (e.g., collaboration with local agencies to develop community-based systems of care), population-based individual services (e.g., Children’s Multidisciplinary Specialty Clinics), enabling and non-health support services (e.g., Parent

Participation Program), and direct health care services (e.g., medical care and treatment services).

The full range of CSHCS program elements and services includes: casefinding; application for CSHCS coverage, assessment of family service needs, and service coordination/case management, specialty medical care and treatment; family support services and opportunities for parent participation in policy development; and specialized home care supports.

Medical care and treatment includes a wide range of services such as physician care, hospitalization, pharmaceuticals, special therapies and durable medical equipment, home health nursing, and orthotics/prosthetics. In addition to making payment for these services, CSHCS assures quality in the services provided. Physicians, hospitals, and clinics must meet established criteria in order to qualify as "approved" providers. These criteria focus on the demonstration of expertise and willingness to provide pediatric specialty services. Along with the approval of providers, CSHCS authorizes specific providers for each child, so that specialty expertise is appropriate for the child's condition. Provider reimbursement policies and rates are the same for both CSHCS and Medicaid.

The Michigan Public Health Code, Public Act 368 of 1978 as amended, defines a CSHCS-eligible person as someone under age 21 "...whose activity is or may become so restricted by disease or deformity as to reduce the individual's normal capacity for education and self-support." Persons over age 21 with cystic fibrosis or hereditary coagulation defects (hemophilia) also may be eligible for services. CSHCS covers chronic physical conditions that require care by medical or surgical specialists. Conditions include, but are not limited to, the following: AIDS/HIV infection; amputation; certain heart conditions; birth defects; epilepsy and other neurologic disorders; cerebral palsy; paralysis/spinal injuries; cleft palate/cleft lip; cystic fibrosis/other chronic lung disease; myelodysplasia; limb deformities; certain visual disorders; hemophilia; muscular dystrophy; and neonatal disease. The program also looks at severity, chronicity and the need to be seen at least once annually by an appropriate pediatric subspecialist in making a medical eligibility

determination.

There are no fees assessed for families whose income is at, or below, 250% of the federal poverty level or for children adopted with a qualifying pre-existing condition. All other families are required to have their income evaluated; these families can choose to participate in the program, subject to a payment agreement established on a sliding-fee scale.

CSHCS is a statewide program, although certain program components may not be available in every county. For example, children's multidisciplinary clinics are associated with tertiary care centers, and family support coordinators may serve more than one county.

Local health departments serve as a community resource to assist families in accessing needed services, both from CSHCS and other local agencies. Local health department CSHCS professionals are encouraged to work closely with their MCH colleagues and with other agencies to identify community service needs from the perspective of children with special health needs and their families. These local collaborative efforts are supported by the state-level approach to community needs assessment and are reflected in efforts to remove artificial, categorical barriers to services.

Local efforts are focused on the earliest intervention possible to prevent, cure or minimize the impact of handicapping conditions on children. In addition to program representation activities for the purpose of casefinding, the local health department system, or the CSHCS Customer Support Section helps families to obtain needed program information and services. Families are offered a “Family Service Needs Summary” by the local health department when the family requests assistance in recognition that the child's disability affects parents, brothers, sisters and other family members. During the service needs summary, local health department professionals help to identify the needs of all family members. Service coordination (formerly case management) can then be provided if the family decides it wants further help in developing self-advocacy skills, problem-solving, or in obtaining

needed services.

Family-Centered, Community-Based, Culturally-Competent, Coordinated Care
This philosophy has been incorporated into all CSHCS strategies for program and policy development, and into the service delivery structure. CSHCS has built an infrastructure which assures both input and feedback with regard to these critical program characteristics. The Parent Participation Program (paid parent consultants to the program), parent membership in the CSHCS Advisory Committee, and the Family Support Network are program elements which reinforce family-centeredness. Formal relationships with local health departments, initiatives to strengthen home-based care, and provider standards all support a community-based approach. Coordinated care is facilitated by state-level inter-agency planning (including coordination among state-level parent support initiatives); local relationships among and between other MCH colleagues and human service agency professionals; broad representation on the CSHCS Advisory Committee; and expectations of specialty clinic providers, primary care physicians, and local health department professionals.

The CSHCS provider approval process assures high quality services and coordination between primary, secondary, and tertiary care services; and provides access to services. The CSHCS provider approval process establishes the structural framework for a network of services fully committed to the model of family-centered, community-based coordinated care. This policy commitment also underpins current managed care initiatives.

The Parent Participation Program has three major areas of responsibility: 1) development of a statewide, community-based network of parent-to-parent support, 2) provision of parental input to CSHCS administration regarding programs and policies; and 3) facilitation of timely responses to families in need. A core component of the CSHCS organization, the program is headed by a parent of a child with special health needs. The program is unique in that it is inclusive of all families of children with special health care needs, whether or not they are enrolled in CSHCS. The Children's Special Health Care Services hotline is operated through the Parent Participation Program (see also Section 4.2).

Two initiatives focus specifically on improving home and community-based supports for children with extensive care needs: the Specialized Home Care Program (SHCP), and CHILDS (Children's Hourly In-Home Locally Delivered Services). The SHCP was developed to respond to the needs of medically fragile, technology-dependent children and their families. It provides specialized care management and payment for hourly nursing care, in addition to the "usual" CSHCS services. CHILDS is an interdepartmental effort, with lead responsibility placed in CSHCS. CHILDS is responsible for developing an infrastructure to implement recommendations made in late 1992 by an interdepartmental workgroup to consolidate and expand services for children and their families needing hourly care (both licensed nursing and personal care). These two programs are in the process of being merged into a single program to simplify application and processing needs for families and staff.

Rehabilitation Services For Children Receiving Benefits Under Title XVI All children eligible for SSI are also eligible for Medicaid in Michigan. Therefore rehabilitation services are typically provided under Title XIX, often in the school under Medicaid-Reimbursed School-Based Services. Michigan Medicaid has a very extensive benefit package, and the need for further coverage would be rare. CSHCS provides medical services as needed based upon the CSHCS qualifying diagnosis. Therefore, CSHCS would provide medically necessary services not covered under Title XIX for children enrolled in CSHCS as the circumstance arises.

1.5.1.3 Other Capacity

The department does not provide direct services, but contracts with local health departments and other community health agencies to provide MCH services. Department staff provide training, consultation and technical assistance to local staff in various programs, certify providers of Maternal and Infant Support Services, determine eligibility for CSHCS program, plan and develop programs, projects and new initiatives, and monitor the performance of local programs. Most of the staff at the state level working on Title V programs are located in the divisions of Family and Community

Health and Children's Special Health Care Services.

In the Division of Family and Community Health, there are 30 professional and 11 support staff working on programs for pregnant women, mothers, infants, children and adolescents. Professional staff is composed of nurses, public health consultants, hearing and vision consultants, nutrition consultant and managers. The Data, Evaluation and Surveillance Unit includes seven staff who collect, analyze and disseminate program information.

The Children's Special Health Care Services Plan Division currently includes 15 professional and 27 support staff. Professional staff is made up of nurses, nutritionists and managers. Support staff perform clerical and eligibility determination functions.

Parents of special needs children perform an advisory role to the department as well as developing support networks across the state for parents of special needs children (see previous section for a description of the Parent Participation Program). The department employs five parents in this program.

The Newborn Screening and Hereditary Disorders Program has three professional and three support staff. Professional staff includes a genetic consultant and two public health consultants.

In addition, there are two MCH epidemiologists in the Bureau of Epidemiology, Community Public Health Administration who provide epidemiology expertise in support of MCH programs.

Virginia Harmon is the deputy director for the Community Living, Children and Families Administration within the Michigan Department of Community Health. In this capacity, she is responsible for the direction of mental health services to children and families as well as family and community public health services. Ms. Harmon also oversees plans of the public mental health system for the return of persons residing in state-operated institutions to their home communities, providing technical assistance as needed to the responsible community mental health service programs; establishes policy, assures the

availability of TA resources and best practices in areas of housing, supports and community living; and serves as liaison with other state systems in the coordination/integration of services and supports.

Ms. Harmon has 25 years experience in mental health administration, starting as Program Director for the Plymouth Center for Human Development to Bureau Director of Community Residential Services in the former Department of Mental Health. Prior to that, she had six years experience as a speech pathologist. Ms. Harmon has a Master's degree in Speech Pathology and a Bachelor's degree in Speech Pathology/Audiology and Psychology.

Jane L. Finn is Director of the Children's Special Health Care Services Plan Division, Medical Services Administration. Previously, Ms. Finn was Chief of the Primary Care Section, responsible for overseeing the development, regulation and technical support of the delivery of primary health care services throughout the state, including Indian and migrant health centers, federally qualified health centers, rural health clinic program and the Michigan Essential Health Provider Program. In addition to these duties, she also served as team co-leader for the CSHCS Managed Care Initiative. For six years, Ms. Finn was a program specialist with the CSHCS Division, responsible for planning and directing statewide insurance objectives, including casualty and liability recovery, alternative health care products, health insurance continuation and cost avoidance; the statewide appeals process and administrative hearings; and prior authorization of services and reimbursement for dental, pharmacy, O.T/P.T., durable medical equipment, medical supplies, orthotics and prosthetics. Prior to that, Ms. Finn was a disability examiner for the Disability Determination Services in the Michigan Department of Education. She specialized in the adjudication of disabled child cases and SSI cases as defined by the Social Security Administration. Ms. Finn also has five years experience with volunteer services programs with the Department of Social Services, participating in training of local office staff, organizing statewide conferences and presenting annual reports to the legislature. Ms. Finn has a Bachelor's degree in social work from Michigan State University.

1.5.2 State Agency Coordination

Executive Order 1996-1, issued in January, 1996, created the Department of Community Health (DCH) by combining the former departments of Mental Health and Public Health and the Office of Services to the Aging and transferring the Medicaid administration to the new department. In addition, the responsibility for provision of mental health services in the state's corrections system was transferred to the Department. The Department of Community Health includes: the Health Legislation and Policy Development Administration; Community Living, Children and Families Administration; Mental Health and Substance Abuse Services Administration; Community Public Health Administration; Budget and Finance Administration; Medical Services Administration; WIC Administration; and the Office of Services to the Aging. (See also Section 4.2) Responsibility for the MCH component of Title V is in the Community Living, Children and Families (CLCF) Administration, and the CSHCS component is in the Medical Services Administration.

The protection of the public's health under the Public Health Code is a partnership between the state and local health departments (LHDs). This partnership continues to evolve with the implementation of Medicaid managed care. The state health department has responsibility for general supervision of the interests of the health and life of the people of Michigan, promoting an adequate system of community health services throughout the state, and developing and establishing arrangements and procedures for the effective coordination and integration of all public health services, including effective cooperation between public and non-public entities to provide a unified system of statewide health care. With the responsibility for many personal care services including maternal and child health services shifted from local public health to qualified health plans, the role of local health departments has changed somewhat to emphasize assurance of community capacity to provide needed services and accountability for the health status of the community. LHDs continue to carry out the core functions and to provide services aimed at communicable disease control, protection of food and water supply, casefinding and service coordination and planning for children with special health care needs, health education and public information. In addition, the LHDs provide a link to other social and public services. The state health department supports the local health system with funding, training, technical assistance and data resources.

The human services departments (Community Health, Education, Family Independence

Agency), along with representatives from the Governor's Office and Department of Management and Budget, meet on a regular basis to coordinate policy and discuss cross-cutting issues affecting their common target populations. The agencies cooperatively implement and monitor activities under the *Systems Reform for Children and Their Families* initiative which seeks to support local collaborative efforts to improve the well-being of children and their families. Staff from the human services agencies provide training and technical assistance and some funding support to local collaborative bodies. In addition, the human services agencies collaborate on several specific program initiatives.

DCH and the Family Independence Agency (formerly the Department of Social Services) continue to work together on outreach activities to low-income families eligible for public programs. Although the Medicaid administration was transferred to DCH, the Family Independence Agency (FIA) continues to provide information and collect applications for Medicaid. DCH and FIA collaborate on policies and processes for making low-income families aware of their eligibility for public assistance programs through various state and local sources, particularly families leaving the TANF program due to increased income or noncompliance with work requirements. The Child Well-Being Program was initiated to provide home visits to families whose FIP cases have been closed due to noncompliance with work requirements to inform them of their potential eligibility for Medicaid, food stamps and other community resources. DCH and FIA also collaborate on family preservation efforts, such as Strong Families/Safe Children and MIFPI (Michigan Interagency Family Preservation Initiative), and the Child Death Review Program. Both departments maintain representation on the State Child Death Review Team. In addition, WIC and FIA coordinate annual outreach campaigns for the WIC nutrition and TANF programs. WIC and FIA are also co-locating services in the Detroit and Wayne County area to increase enrollment of the eligible population in those areas.

DCH and the Department of Education collaborate on school health programs and work together on the Early On initiative (Part H of IDEA). The activities of the Early On program are directed by the State Interagency Coordinating Council and includes technical assistance and training for local coordinating councils. Staff from the Division of Family and Community Health, the Division of Mental Health Services to Children and Families, and CSHCS participate on the state council. The departments also cooperate in administering

the Youth Risk Behavior Survey.

DCH joined with the Departments of Agriculture and Environmental Quality in developing and implementing the Michigan Local Public Health Accreditation Program. This program institutes a baseline standard for characteristics and services that define a local health department. The program includes a self-assessment and on-site review components and is operated on a three-year cycle. DCH contracts with the Michigan Public Health Institute to house, staff and coordinate the program. More information on this program can be found at www.accreditation.localhealth.net.

The Michigan Public Health Institute, a non-profit corporation, was authorized by Public Act 264 of 1989 as a cooperative venture of the Michigan Department of Public (now Community) Health, the University of Michigan, Michigan State University and Wayne State University to plan, promote and coordinate public health research, evaluations and demonstrations. The Institute's board of directors includes representatives from each of the universities and the department. Since its creation, the Institute has worked with the department on several important initiatives including: evaluation (e.g., Maternal Support Services, Michigan Abstinence Partnership, Local Public Health Accreditation Program); developing new programs and projects (e.g., Opening Doors in Michigan, expansion of child death review teams statewide); training and technical assistance activities (e.g., development of a standard tool for reporting death scene investigations of sudden and unexplained child deaths and training of local child death review team members); and data collection and reporting (e.g., child death review database, PRAMS).

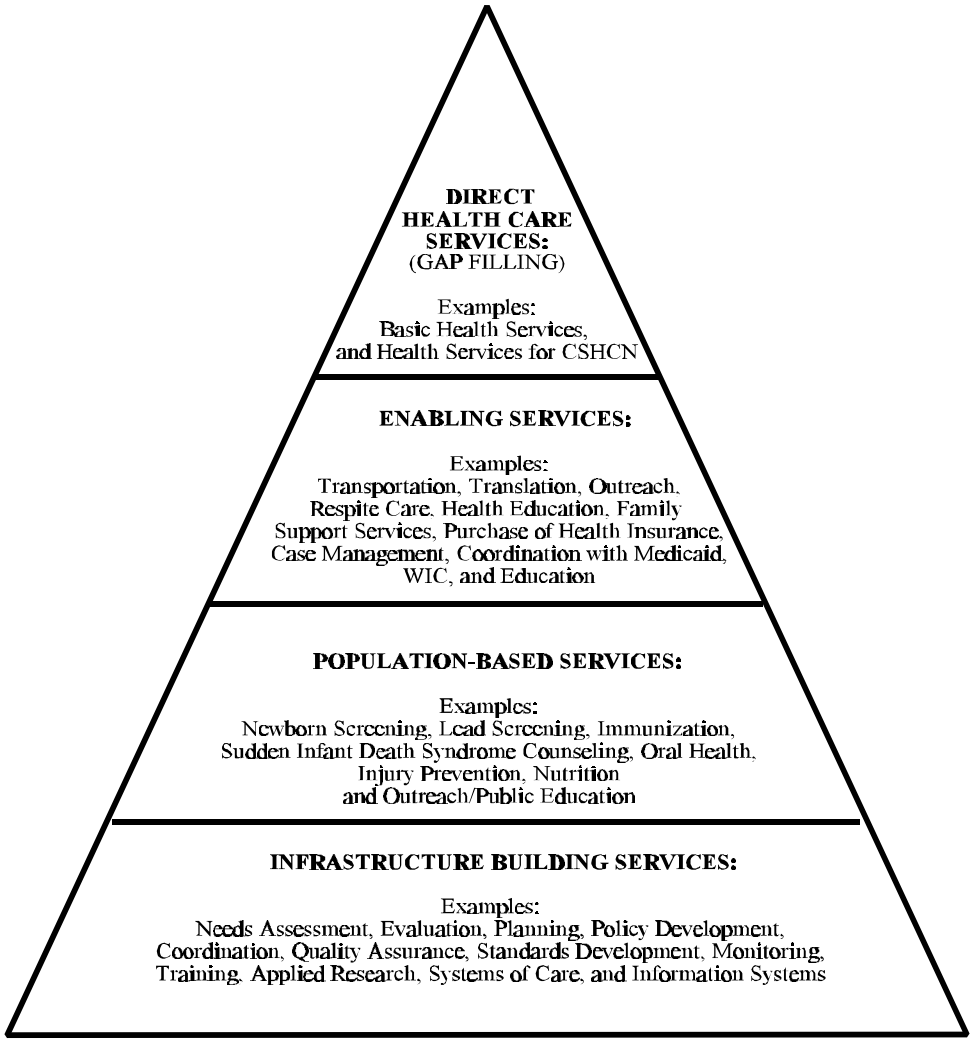
II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

See Section V. Supporting Documents, 5.8 All Other Forms, Forms 3, 4 and 5

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/OSCH 10/20/97

2.2 Annual Number of Individuals Served

See Section V. Supporting Documents, 5.8 All Other Forms, Forms 6, 7, 8 and 9

2.3 State Summary Profile

See Section V. Supporting Documents, 5.8 All Other Forms, Form 10

2.4 Progress on Annual Performance Measures

- Direct Health Care

Pregnant Women, Mothers and Infants

No performance measures.

Preventive and Primary Care Services for Children

SP# 05 - Percentage of children screened with elevated blood lead levels.

1996	1997	1998	1999	*Target*
6.8%	9.4%	9.7%	6.8%	*6.1%*

Progress: The 1999 percentage of children decreased from the 1998 level, however, we did not succeed in meeting the target. Michigan was in a unique position in the last year, where we expected to increase the percentage of children with elevated blood lead levels before the percentage is reduced. At that time, screening was focused on high risk children, for whom we expected to have a higher percentage of elevated levels. As we began to move toward universal screening, a smaller proportion of the children screened are at high risk for lead poisoning. We expected to see, and did for 1999, a reduction in the percentage of children screened who had elevated levels. The reporting of children screened has improved greatly with the implementation of an administrative

rule requiring the reporting. Having an universal number of screens performed will give us the needed baseline against which to measure our progress.

Services for Children with Special Health Care Needs

Core #01 - Percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program

1997	1998	1999	*Target*
15.7%	16.0%	19.3%	*16.5%*

Progress: Previous reports have included children in Michigan for whom SSI payments have been made as well as those identified as on "SSI related" programs. This year Michigan used the numbers received from the Institute for Child Health Policy which identifies the number of children for whom SSI payments have been made only. Therefore, the numbers and percentages are somewhat different due to this change in reporting methodology. All children in Michigan who receive SSI coverage are also eligible for Medicaid coverage and are therefore entitled to receive rehabilitative services through that coverage. Some of those children are also eligible for and covered by CSHCS due to a medically eligible diagnosis. The CSHCS program does not distinguish between rehabilitative services versus habilitative services, and is therefore only able to identify the number of children receiving CSHCS coverage and services. It is believed that most of the necessary rehabilitative services for these children are provided through the schools and reimbursed by their Title XIX coverage. In the event a child has both CSHCS and SSI coverage, and requires a non-experimental medical service related to the CSHCS qualifying diagnosis that is not covered by Michigan Medicaid, the CSHCS program will provide coverage for the necessary service.

Core #02 - Degree to which the State CSHCN Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Progress: CSHCS reimburses providers directly for all specialty and subspecialty

services provided to beneficiaries in the CSHCS Fee-For-Service Plan when services are related to the beneficiary's qualifying condition(s). CSHCS pays the CSHCS Special Health Plans (SHP) on a capitated basis to render all covered services to their enrolled SHP membership. Care coordination is authorized, delivered and reimbursed on a case-by-case basis in the Fee-For-Service Plan. The total number of beneficiaries with CSHCS coverage receiving care coordination has increased as Special Health Care Plan contractors are required to provide care coordination to all enrolled members.

SP #07 - Percentage of Individualized Health Care Plans established for children with special health care needs.

1998	1999	*Target*
0.0%	58.3%	*100.0%*

Progress: This measure was new for FY '98, as implementation of the CSHCS Special Health Plans began September 1, 1998, and therefore there were no reportable results at that time. For FY '99, tracking and reporting of this requirement did not begin until March '99. One of the CSHCS SHPs had a larger than expected enrollment response at implementation which resulted in a backlog of IHCP completion for the members in that plan. Meanwhile, medical care with established providers and some care coordination was provided for the members. Services were not disrupted. Lessons have been learned regarding best practices for the establishment of IHCPs, and additional staff have been hired to meet the need. IHCP completion has significantly improved over the past eight months. The percentage of completed IHCPs over the course of this year of implementation is determined to be 58.3%. The target is 100%. The other CSHCS Special Health Plan was successful in meeting state expectations in the completion of member IHCPs, delivery of care coordination and establishment of a medical home through the principal coordinating physician.

- Enabling Services

Pregnant Women, Mothers and Infants

SP #01 - Percentage of Black preterm births in Michigan.

1995	1996	1997	1998	*Target*
18.5%	18.1%	18.1%	16.7%	*17.7%*

Progress: 1999 percentage saw a significant drop in the percentage of Black preterm births. This is a significant occurrence that can have a meaningful impact on Michigan's infant health statistics. Many of the general efforts to improve infant mortality contributed to the reduction of Black preterm birth rates. These efforts are the same as cited in several other objectives: prenatal care outreach, prenatal care access and support, teen pregnancy reduction, prenatal smoking cessation, increased access to family planning, etc. To target the African American population, we concentrate efforts in the state's population centers where the highest proportion of this population resides. There is continuous work to assure that outreach and services are culturally sensitive to target populations.

SP #02 - Percentage of term low birth weight births in Michigan.

1995	1996	1997	1998	*Target*
2.8%	2.7%	2.7%	2.5%	*2.7%*

Progress: Term low birth weight dipped from 1997 to 1998, allowing the state to meet its target. All the support, outreach and assurance services for pregnant women will continue. We will continue to try to identify through data analysis what contributors will improve our ability to affect this measure.

Preventive and Primary Care Services for Children

SP #09 - The State has developed a program to increase access to preventive and remedial oral health for low income children.

Progress: Michigan's Child Health Insurance Program (MIChild) has included oral health coverage for the children who are insured under the program. Dental care has been one

of the highest utilized services in the MIChild program. Increased funding in the FY 2000 dental Medicaid budget will improve access to oral health services through capacity building grants to community agencies and a private insurance model pilot for Medicaid eligible children in 22 counties.

Services for Children with Special Health Care Needs

Core #03 - Percent of CSHCN in the State who have a "medical/health home."

1997	1998	1999	*Target*
9.5%	14.1%	21.2%	*39.5%*

Progress: There are children with CSHCS coverage who have a medical home through private HMO coverage. CSHCS services are provided to those beneficiaries in the event their benefits do not cover all necessary services for the CSHCS qualifying diagnosis. These children are identified as having a medical home. In addition, Michigan has implemented a specially-designed managed care plan for CSHCS called Special Health Plans (SHP). The SHPs must provide access to an identified principal coordinating physician who provides a medical home for those children who voluntarily enroll with a SHP. Enrollment into Special Health Plans began in September of 1998 in 6 out of 83 Michigan counties. One SHP expanded into one additional county in FY '99. This first full fiscal year has required significant focus on program operations within these counties of implementation, therefore the number of children having a "medical home" for FY '99 is still based upon the count of children who have joined a SHP within these 7 counties. FY '00 will have children identified in additional counties due to Special Health Plan expansion. In addition, enrollment into one of the SHPs was frozen during a significant portion of FY '99 (from 9/1/99 - present) because they had a sudden and large influx of enrollment at the beginning before they had capacity to service such a sudden population. The SHP needed additional time to provide the care coordination requirements in the appropriate contract (including IHCP development) to the large enrolled population at the point of implementation. Therefore, enrollment did not reach the targeted goal in FY'99.

SP #04 - Percentage of those enrolled with a Special Health Plan having an identified care coordinator.

1999	*Target*
80.5%	*100.0%*

Progress: This measure was new for FY '98, as implementation of the CSHCS Special Health Plans began September 1, 1998, and therefore there were no reportable results at that time. For FY '99, tracking and reporting of this requirement did not begin until March '99. One of the CSHCS SHPs had a larger than expected enrollment response at implementation which resulted in a backlog of IHCPs for the members in that plan. Services were not disrupted. The percentage of those enrolled in a SHP and having an identified care coordinator in FY '99 is 80.5%. The families often identify the individual they would like to have function in this role. The SHPs have been successful in gaining agreement and making arrangements in most cases with the individual selected by the family. In the event the individual declines, the SHP assists the family in identifying another person to be their care coordinator.

- Population Based Services

Pregnant Women, Mothers and Infants

Core #04 - Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g.the sickle cell disease) (combined)].

1995	1996	1997	1998	1999	*Target*
100%	100%	100%	100%	100%	*100%*

Progress: All newborns in the State were screened for PKU, hypothyroidism, galactosemia, sickle cell, MSUD, biotinidase deficiency, and congenital adrenal hyperplasia. *Note: In past years the newborn screening database was used to estimate the occurrent births for the reporting year. For the first time this year we have an*

estimate of occurrent births from the state Vital Records (provisional data).

Core #06 - The rate of births (per 1,000) for teenagers aged 15 through 17 years.

1995	1996	1997	1998	*Target*
30.9	28.9	25.4	25.4	*29.1*

Progress: See SP #08 below.

Core #09 - Percentage of mothers who breast-feed their infants at hospital discharge.

Source:	1996	1997	1998	*Target*
Ross	53.0%	56.8%	59.4	*59.1%*
PNSS	40.9%	42.4%	43.9%	*59.1%*

Progress: While the breast-feeding initiation rates have increased steadily among Michigan mothers and Michigan WIC mothers, the prevalence of breast-feeding are below the national average (64%) and well below the Healthy People 2010 Target (75%). Continuing efforts are made through Michigan WIC Program to provide encouragement, support and information to low-income mothers in order to promote breast-feeding.

Core #10 - Percentage of newborns who have been screened for hearing impairment before hospital discharge.

1997	1998	1999	*Target*
9.1%	25.1%	48.4%	*50%*

Progress: Additional hospitals have joined the effort, nearly doubling the percentage of newborns screened in 1999 over the previous year. Since 1996, Michigan began encouraging and supporting hospitals to perform the newborn hearing test on all infants in their nurseries. Currently, there are 64 hospitals screening with another 21 expected to implement a program by the end of FY 2000. Many hospitals have joined in program development in anticipation of a new Medicaid policy requiring that hospitals with 15 or

more Medicaid-reimbursed births provide an in-hospital hearing screen. This policy will become effective June 1, 2000.

SP #03 - Percentage of pregnancies that are unintended.

1995	1996	1997	*Target*
49.4%	49.3%	44.3%	*48.2%*

Progress: The percentage of unintended pregnancies decreased in 1997. Michigan continues to promote, and has received increased resources for, the Family Planning program, a primary strategy for reducing unintendedness. In addition, the Michigan Abstinence Partnership has operated for the second year with federal Abstinence Education funds to expand the efforts in the youth population to abstinence from sexual activity. Abstinence education will contribute to reducing unintended pregnancies in the teen population where more than 70% of pregnancies are unintended.

All prenatal programs have a service component that connects women postnatally to family planning services, either the Title X program or their medical provider. Pregnancy prevention is a responsibility of both partners. Many programs are beginning to highlight the responsibility of the male. Sterilization service has been expanded to having a focus on male clients as well. A second specialized sterilization service site was started and is now fully operational providing services to both males and females.

SP #08 - The rate of pregnancy to female teenagers aged 15-17.

1995	1996	1997	1998	*Target*
49.4%	47.3%	41.2%	40.8%	*47.9%*

Progress: The percentage of unintended pregnancies decreased again in 1998. The same efforts that effected a reduction in unintended pregnancies have contributed to the reduction of teenage pregnancy. See SP# 03 above.

Preventive and Primary Care Services for Children

Core #05 - Percent of children through age 2 who have completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus Influenza, Hepatitis B.

1995	1996	1997	1998	*Target*
67.4%	74.1%	76.5%	79.8	*82.0%*

Progress: While we haven't met the goal, immunization coverage levels continue to increase. In addition, it is anticipated that increasing use of the Michigan Childhood Immunization Registry by providers to assess children's immunization status and implementation of the registry's recall and reminder function will have a positive impact on immunization levels and assist us in reaching our goal. The educational emphasis with the general population and collaboration with the provider community to achieve the ultimate goal of 90% of all two year olds being appropriately immunized has been progressing very well.

Core #07 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

1997	1998	1999	*Target*
27.1%	27.1%	31.9%	*31.0%*

Progress: The improvement in this measure in FY '99 is due to an increase in Medicaid reimbursement to providers for services and an increase in the number of insured children in the MIChild program which covers sealants for the age group.

Core #08 - The rate of death to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

1996	1997	1998	*Target*
5.3	5.1	5.4	*5.0*

Progress: This rate increased for 1998 in spite of the state's continuing efforts. All the strategies continue: education, legislation and engineering redesigns. The Department's promotional efforts focused on increasing the use of safety belts and seats, bicycle helmets and vehicle safety promotion for children as bikers and pedestrians. Other factors were engineering changes (safer road and vehicle designs) and legislation (child passenger safety law).

Services for Children with Special Health Care Needs

No performance measures.

- Infrastructure Building Services

Pregnant Women, Mothers and Infants

Core #15 - Percent of very low birth weight live births.

1995	1996	1997	1998	*Target*
1.5%	1.5%	1.6%	1.6%	*1.4%*

Progress: Progress toward the very low birth weight target has continued to elude the state, remaining at the same level in 1998. VLBW is associated with preterm labor which occurs because of issues linked to maternal health. The rise in multiple gestation may be affecting this finding, but the emerging challenge of improving maternal health is a much broader issue. Factors such as nutrition, care for chronic illness, treatment of infections and eliminating use of substances all service to improve the gestational age. All of the current efforts to promote early and consistent prenatal care, support and access will contribute to the achievement of this objective. Michigan Fetal Infant Mortality Reviews hopefully will provide some insight to contributing causes and potential strategies to achieve this objective.

Core #17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

1995	1996	1997	1998	*Target*
83.9%	81.3%	85.0 %	81.5%	*84.6%*

Progress: Michigan's rural geography, with significant population living away from the population centers where the high risk delivery facilities are located, makes this objective even more challenging to achieve. However, with the continuous and consistent promotion of early and adequate prenatal care and prenatal support services, we are making some headway. 1998 demonstrated a slippage in the percentage of VLBW infants who were born in high risk delivery facilities from 1997, however still an increase from 1996.

Core #18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

1995	1996	1997	1998	*Target*
81.3%	81.2%	81.2%	81.0%	*83.5%*

Progress: This performance measure showed some improvement in 1998. Michigan continues it many efforts to improve access and education for all pregnant women to seek early prenatal care. Michigan has continued it's liberal financial Medicaid eligibility criteria, and numerous support programs: Maternal Support Services, Maternal and Infant Health Advocacy Support services, prenatal hot lines, outreach by local health agencies to facilitate access to prenatal care and Medicaid enrollment, enrolling all Medicaid clients with a medical care home, and support of women who are low income but for unique reasons do not qualify for Medicaid. The Title V agency works with the local agencies that have obtained Healthy Start funding to operate programs that will contribute to achieving this objective.

Preventive and Primary Care Services for Children

Core #12 - Percent of children without health insurance.

1996	1997	1998	1999	*Target*
8.9%	8.3%	8.4%	5.6%	*7.3%*

Progress: Michigan saw a significant improvement in 1999 with the implementation of the MIChild Program, the state's Child Health Insurance Program. Our targets for future years have been reduced as a reflection of increased resources to insure a significant proportion of the child population. The outreach efforts for the program has helped to identify a significant number of children who were eligible for the Medicaid program. The coordinated eligibility determination effort has benefitted both programs, helping the state to achieve its objectives.

Core #13 - Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program.

1996	1997	1998	1999	*Target*
74.3%	71.7%	82.7%		*78.5%*

Progress: While the percent of children enrolled in Medicaid declined slightly from 1996 to 1997, a significant improvement in 1998 and onward is expected with the creation of the state CHIP program, MIChild, and the dual promotion of MIChild and the Michigan Medicaid program for children, Healthy Kids. The outreach efforts for these programs is being performed concomitantly. The outreach efforts have taken an approach of "no wrong door" for access to enrollment into these health care coverage services.

Core #16 - The rate (per 100,000) of suicide deaths among youths aged 15-19.

1995	1996	1997	1998	*Target*
10.7%	8.8%	10.6%	8.4%	*9.7%*

Progress: The decrease of adolescent suicide in 1998 creates an erratic pattern in the rate that will require epidemiologic analysis. While we cannot confirm the cause of this occurrence, the preventive services previously in place have continued: community mental health services, adolescent health centers and referral services, and aggressive promotion of an adolescent health screening protocol (Guidelines for Adolescent Preventive Services) that identifies indicators of emotionally troubled youth.

SP #06 - State has implemented a valid Youth Risk Behavior Survey (YRBS) and has established baseline measures for violence, sex, substance use, intentional and unintentional injury.

Progress: For the second time, the 1999 Survey's sample size and construction is representative of the state's youth population. Based on the results from this survey, baseline measures for selected health issues have been established, as well as first year trend data.

Services for Children with Special Health Care Needs

Core #11 - Percent of CSHCN in the State program with a source of insurance for primary and specialty care.

1997	1998	1999	*Target*
88.5%	89.2%	90.5%	*92.0%*

Progress: 51% of CSHCS members also have Medicaid coverage (number includes some children who also have other insurance). In addition, 53.2% of children in CSHCS have a source of insurance for primary and specialty care other than CSHCS (number includes some children who also have Medicaid). Many children with CSHCS are also covered by the Michigan CHIP program called MIChild (not included in the figure above). Children with eligibility for both CSHCS and MIChild, who live in a county with a SHP receive both coverages through the SHP. Children in CSHCS and MIChild who live in counties where there is no SHP option receive MIChild services from the Blue Cross/Blue Shield MIChild contractor who coordinates with CSHCS.

Core #14 - The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

Progress: The Parent Participation Program (PPP) employs five parents of children with special health care needs. The PPP is an integral part of CSHCS Plan Division and is treated as a section within the division. All written materials intended for families, as well as CSHCS policy and procedure, is reviewed by this group for recommendation and revision as needed. Furthermore, family participation has been and continues to be a main feature in the development and implementation of the contractual requirements for the Special Health Plans. Therefore, significant contractual requirements included are a direct result of the family participation in the administration of the SHP contract and in the care decisions and management of the enrolled child under these contracts. Children enrolled in the SHPs benefit from the additional family participation involved in the development of the family centered requirements, which include participation on various SHP boards. Family participation is also a constant regarding other CSHCS program policy development. Proposed policies, letters to families, procedural and other documents undergo review, comment, and recommendation by parent representatives as a regular course of events.

2.5 Progress on Outcome Measures

See Section V. Supporting Documents, 5.8 All Other Forms, Form 12

Vital records data for 1999 are still being compiled, therefore, progress on the outcome measures are assessed through 1998.

The infant mortality rate rose slightly in 1998 compared to 1997. The non-Hispanic white infant mortality rate rose slightly, while the non-Hispanic black infant mortality rate decreased slightly, resulting in a decrease in the black to white IM ratio. The neonatal mortality rate decreased for both non-Hispanic black and non-Hispanic white infants. The postneonatal mortality rate increased for non-Hispanic white infants and decreased for non-Hispanic black infants, resulting in a decrease in the ratio of black to white postneonatal mortality.

The percent of live births with very low birth weight remained the same, while the percent of live births with low birth weight rose slightly. The main contributing factor to this rise was a rise in the non-Hispanic black LBW rate. The SIDS rate remained stable. The rate of adequate prenatal care as measured by the Kessner Index decreased slightly from 75.9% in 1997 to 74.8% in 1998. The percent of preterm births also rose in 1998 in both the non-Hispanic black and white populations.

A host of programs will continue to be offered with an emphasis on pregnant women getting into prenatal care as early as possible and addressing any barriers to access. The Maternal and Infant Health Advocacy Services (MIHAS) and the Maternal Support Services (MSS) programs continue to be major contributors to this goal, and both include risk assessments and multiple home visits in their models. WIC, Prenatal Smoking Cessation and the Maternal and Child HIV/AIDS program also impact prenatal behaviors and, therefore, birth outcomes. The Michigan Abstinence Partnership, Family Planning, MIHAS, MSS, Adolescent Health and the Michigan Model education program in the schools all contribute to reducing the number of unintended pregnancies.

The black IM rate remains much higher than the white IM rate, but improved somewhat during this period. Special targeting of the African American population with the “Back to Sleep” campaign for SIDS prevention, Infant Support Services (ISS), as well as new initiatives targeting children zero to three should continue to impact infant mortality, especially black infant mortality. Information gathered from the Fetal Infant Mortality Review and Child Death Review teams continue to influence the revision of current policies and programs and the development of new ones.

The child death rate increased slightly in 1998. The mortality rate from unintentional injuries for white and black children 0-9 increased, whereas it decreased among white and black children 10-19 years old. The child death rate should continue to be impacted by mandatory seatbelt laws, enforcement of drunken driving laws, and prevention programming. The continued expansion of child death and fetal/infant mortality review teams will provide information for local and state decision makers to adjust policies, programs and public information campaigns to impact child death.

III. REQUIREMENTS FOR APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

The Department convened a MCH Needs Assessment workgroup in June, 1999 to begin the needs assessment process. The workgroup included representatives from state MCH and CSHCN programs, local health departments, a local Healthy Start project, Medicaid, Vital Statistics, epidemiology and children's mental health. The workgroup reviewed health status indicators and both the national and state performance measures, and added indicators or programs that were not included but impacted the health of the three population groups: pregnant women, mothers and infants; children; and the CSHCN population. The expanded draft document was then distributed for input to a broad segment of the MCH network, including the Community Living, Children & Families Advisory Committee which includes parents, and health care providers/policy makers from the private and public sectors. All representatives of the public and private sector were asked to gather input from local programs and consumers on two factors: the ability to collect data locally on these measures and the usefulness of particular measures to direct policy and programs in MCH in their jurisdiction.

Following incorporation of the additional indicators, data was compiled on all measures as available. The workgroup met in February 2000 to review the data and trends for each of the measures. Per the previous meeting, discussion of each measure included data on previous years, national data for comparison, and any relevant Healthy People 2010 objective. Following the review and discussion, members of the group voted in ranked order for the priority measures which should be addressed through MCH programming over the next five years. This prioritized list was reviewed, along with trend data with the program managers in maternal and child health and CSHCN. Specific programmatic efforts were reviewed and the top nine programmatic priorities identified. Target numbers for 2005 were established. A subsequent meeting was held with agency consultants to review the trends and discuss programmatic activities and needs to confirm the priorities, discuss interventions and set 2005 targets.

The limitations of Michigan's data identified during the needs assessment process included problems with some definitions and missing fields on the birth and death certificates which made analysis difficult. Some indicators did not have sufficient years of data to develop a reliable trend projection. Also, in some cases, there were no reliable sources of data to measure progress or the only data was program specific rather than population-based data and thus could not be applied to the health of the MCH population at large. Probably the major issue was that the data for many MCH programs as well as for Medicaid and WIC are not linked to the birth certificate database. This issue resulted in the identification of database linkage as a priority need.

The sources used for development of the MCH priorities and data measures included vital records, program specific information, annual reports from local providers, Medicaid program reports and local agency survey of needs reports, as well as numerous discussions with program and data staff. The strength of the needs assessment process was that it combined input from both the MCH program staff and the data or epidemiology staff at the state and local levels. Consequently it provided an opportunity for shared consideration and discussion of the outcomes in MCH populations, the states' progress in relationship to Healthy People 2010 objectives and a chance to review trends of the previous years.

One weakness of the methods and procedures for the needs assessment was that it was difficult, despite a variety of attempts, to get consumer input during the process. Thus there are minimal comments on the MCH outcomes from consumers of MCH services. A second weakness continues to be the struggle to fit the needs assessment process into the pyramid structure. However, this was addressed by identifying the programs that impact the priority needs and outcomes and, as such, the program categorization of the pyramid was useful.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population Health Status

In reviewing the Michigan MCH population, many of the changes and outcomes from 1990-1998 mirror health status changes being seen nationally. (See Section 5.3) During this period, the total population in Michigan increased by 5.6%, whereas the total live

births decreased by 12.7% from 153,080 in 1990 to 133,649 in 1998. The female teenage population increased 6.6%, while the number of females 20-34 years of age decreased by 11.1%. The overall fertility rates in Michigan dropped from 68.9 live births per 1,000 female population 15-44 years old in 1990 to 60.0 in 1998. The largest decrease in fertility rate was in the black population from 92.7 in 1990 to 66.3 in 1998, compared to a decrease in the rate for the white population from 64.5 to 58.2 in 1990 and 1998, respectively.

The priority health problems of Michigan's MCH population are those shown on Form 14. They include maternal mortality, unintended pregnancy, repeat births to unwed women 15-19 years of age, lead poisoning in children 0-6 years of age, hearing problems of young children, injuries to children in the 1-14 year old population, access to dental services and enrollment in a managed care special health plan in the CSHCN population. The mortality rate from unintentional injuries to children 1-9 years of age shows an upward trend in the past four years from 16.4 per 100,000 in 1995 to 21.7 in 1998. Infant mortality continues to be a problem in Michigan, specifically the racial disparity between the black infant mortality rate of 16.8 and the white infant mortality rate of 6.3. Further analysis appears to indicate that programmatic efforts to reduce these disparities need to target low birth weight and the health status of infants born to black women during the post-neonatal period. Additionally, the racial disparity analysis of infant mortality reflects a 36% higher rate of death for American Indians than among white infants in 1998.

Michigan's racial disparity in maternal mortality is the highest in the country at 18.7 for black women compared to 2.8 for white women during the 1990-1998 period. The Vital Records data used for this measure are very small and the definition in the Healthy People 2010 objective uses 42 days as the period measured. In Michigan, analysis of this data has resulted in a decision to change the state's maternal mortality surveillance system, including the review process and case identification. The new surveillance system will include both medical and non-medical maternal death review with a definition expanded to death within 365 days after the birth. Preliminary review indicates approximately 60 maternal deaths per year by this methodology. Additionally it appears that programs to reduce pregnancy-related deaths need to target particularly young black

women less than 30 years of age, as well as homicide deaths.

Although Michigan's teen pregnancy rate has continued to decrease and remains below the national rate, the repeat live birth rate for unwed women 15-19 years of age continues to be of concern. Of additional concern is the racial disparity in this population: repeat live births to black teen mothers is 50-70% higher than to white teen mothers. This age group also makes up 88.3 percent of the unintended pregnancies in Michigan according to PRAMS 1997 data and 11.6% of the inadequate prenatal care population in 1998. The unintended pregnancy rate has remained essentially flat at 43% in recent years with the Medicaid population making up the largest portion of the unintended pregnancies at 66%.

Preterm delivery is increasing in Michigan in recent years, as it is nationally, and there is a need for additional programmatic efforts to address and target activities. Michigan's preterm births are higher than the national average at 9.6 percent of live births compared to 9.1 percent nationally. Additionally the percent of preterm infants for black mothers is 1.7 times more than that for white mothers. Similarly, the concern regarding low birth weight births remains a priority. The percent of live births with birth weight less than 2500 grams has increased since 1990 from 7.6 to 7.9 percent of live births in 1998. The 1998 rate is 58% higher than the Healthy People 2010 goal of 5.0%. Again, there is a racial disparity between the black and white populations in low birth weight births in relationship to the proportion of black women of childbearing age in the total state population.

The lead screening of high risk children 0-6 years of age is a priority for Michigan. Although the number of persons screened for lead poisoning continues to increase in our state, the goal of screening all children at risk, particularly all Medicaid children and children living in high risk zip code areas, has not yet been accomplished. In order to measure progress on this performance measure, enrollment data from Medicaid database and the data from the lead screening database will need to be linked. Although discussions regarding this linkage have begun, this process is not completed. Consequently, it is not possible to include baseline data nor project a 2005 target for this measure.

Health system constraints for collection of service outcome information on the MCH population includes the lack of a health survey of the population 1-14 years of age to determine the prevalence of health conditions, as well as identification of barriers to access to care. Additionally, with the shift in Medicaid to a managed care delivery system, the designation of Medicaid status on the birth certificate has become more unreliable. Consequently, the linkage of the birth certificate and Medicaid enrollment databases is needed to assure service delivery to the high risk MCH population. Data linkage of other MCH program files with the birth certificate and WIC files is also necessary in order to monitor program impact and evaluate progress toward MCH outcomes. Finally, Michigan continues to fund the Pregnancy Risk Assessment Monitoring System (PRAMS) independently since 1997 when CDC funding was discontinued. This is a critical survey of the behaviors of pregnant women in our state and the only source of data on the unintendedness of pregnancy.

The universal number of Michigan children with special health care needs is not known, and the number would vary depending upon the definition of “special needs”. The Michigan Children’s Special Health Care Services (CSHCS) data provides information only on those beneficiaries who participate in the CSHCS program. The CSHCS program is undergoing significant revision due to changing technology, both medical and informational, and a rapidly changing environment within which medical services are provided. The result of these changing circumstances, is a change in some of the focus and needs as identified in the previous needs assessment.

Since the last needs assessment was submitted, Michigan’s CSHCS program has turned it’s focus to developing, making available, and providing medical homes to CSHCS beneficiaries through our managed care model of the CSHCS Special Health Plans (SHP). Our emphasis has moved to quality improvement regarding the medical care being provided, data collection regarding that care, and the service delivery systems within which those services are provided.

CSHCS is on the fast track to upgrade our systems, making them more compatible with other systems with which we need to integrate or collaborate such as the Medical Services Administration which administers the Medicaid, the MIChild, and other

programs. This upgrading process requires significant modification toward a more automated system, to address current data needs which has not been accessible through previous systems.

In addition, our move to using managed care delivery systems has established another need for additional data relative to those delivery systems. We are attempting to address those needs through systems development, and incorporating certain reporting requirements from the SHPs which will provide more congruent information than we have been able to ascertain in the past from the Fee-For-Service system. The SHPs will be providing HEDIS information as well as specific encounter data, and participating in the External Quality Review (EQR) process. Michigan CSHCS has completed multiple satisfaction surveys of beneficiaries which have not been done before. The program is also completing preparations to participate in the CAHPS survey, as well as perform follow-up surveys with families who participated in earlier surveys to determine if they have any additional feedback now that they have more experience with the new processes. Michigan is also cooperating with an evaluation funded by an outside grant being designed to evaluate the care and outcomes for children with special needs who receive their care through the SHPs, and conducted by the University of Michigan. All of these efforts are intended to address the additional data that is needed when designing, implementing, and revising new systems of service delivery and program administration.

3.1.2.2 Direct Health Care Services

Direct Health Care - Family planning
Nutrition education and counseling
Prenatal risk reduction
Reduction of substance abuse
Adolescent health primary and preventive services
Lead poisoning prevention
Medical care and treatment for CSHCS
Infant and early childhood support services

See Enabling Services, below, for further discussion of needs of the general MCH

population.

All children in Michigan who receive SSI coverage, are also eligible for Medicaid coverage, and are therefore entitled to receive rehabilitative services through that coverage. Some of those children are also eligible for and covered by CSHCS due to a medically eligible diagnosis. The CSHCS program does not distinguish between rehabilitative services versus habilitative services, and is therefore only able to identify the number of children with SSI coverage who are receiving CSHCS covered services. It is believed that most of the necessary rehabilitative services are provided through the schools and reimbursed by their Title XIX coverage. In the event a child has both CSHCS and SSI coverage, and requires a non-experimental medical service related to the CSHCS qualifying diagnosis that is not covered by Michigan Medicaid, the CSHCS program will provide coverage for the necessary service. No additional need has been identified for this population regarding CSHCS services.

CSHCS reimburses providers directly for all specialty and subspecialty services provided to beneficiaries in the CSHCS Fee-For-Service Plan when services are related to the beneficiary's qualifying condition(s). CSHCS pays the Special Health Plans (SHP) on a capitated basis to render all covered services to their enrolled SHP membership. Care coordination is authorized, delivered and reimbursed on a case-by-case basis in the Fee-For-Service Plan. The total number of beneficiaries with CSHCS coverage receiving care coordination services has increased as SHP contractors are required to provide care coordination to enrolled members. There has been no additional need identified regarding the payment for specialty and specialty medical services (except for dental/orthodontia - see below). Increased care coordination still remains as a need for the population. This need is expected to decrease as the CSHCS SHPs expand across the state, and become accessible to more CSHCS beneficiaries.

The need for Individual Health Care Plans (IHCPs) for CSHCS beneficiaries enrolled in the SHPs is beginning to be addressed with a 58% success rate, but remains as a need. The majority of SHP enrollees in the last fiscal year did have an IHCP established, but due to start-up implementation difficulties the process was not as comprehensive as it had been predicted to be. Most of the implementation difficulties are expected to be

resolved by the next reporting period. As the IHCPs occur regularly for the entire enrolled population, the need will move to increasing the number of SHP enrollees in order to increase the number of CSHCS beneficiaries receiving the benefits of the IHCP. There is also a strong need to increase the number in the SHPs in order to keep the SHPs a viable alternative which makes the benefit of having an IHCP possible.

3.1.2.3 Enabling Services

Enabling Services - Prenatal outreach services
Access to medical and psychosocial intervention
Care coordination and family support services for CSHCS population
Expand Medicaid and other financial source coverage for children's health care services

For both direct health care and enabling services, the priority state concerns continue to be assuring access to health care. For both the general population and the population of children with special health care needs, Michigan continues to pursue an agenda of working with "qualified health plans" (plans that meet minimum requirements for quality and access to care) to assure that all pregnant women, children, and children with special health care needs have a health care home that assumes overall responsibility for their health care needs. Michigan feels that qualified health plans offer three extremely important benefits to the state; those being:

1) management of systems of care that can be held accountable for performance and quality of care. Historical fee for service systems require the state to work individually with literally thousands of providers making accountability almost impossible. In addition, contracts with "systems" of care allow for standards and accountability related to access to care, cultural acceptance, compliance with preventive care standards and customer satisfaction.

2) access to networks of providers. Prior to managed care there were often problems with getting providers to accept Medicaid patients under FFS systems.

Providers contracted with managed care systems are required to accept patients affiliated with the each plan.

3) predictability of cost. This allows the state to assure that budgets will be adequate to provide the provision of care desired.

In Michigan, over the past five years, there has been a significant change away from the delivery of direct services by local health departments. With the advent of managed care systems, and the resulting assurance of a health care provider, local health departments have shifted their focus much more to working to find and assist women and children in need of health care coverage to become enrolled and assuring that community resources are available to provide services. Fortunately, because of this emphasis, there has **not** been a tremendous decrease in the numbers of families covered by Medicaid in Michigan (a result that many other states have in fact experienced). We have put much effort into assuring that women and children who are no longer on cash assistance retain their Medicaid coverage and are not inadvertently disenrolled.

The most significant change that has occurred over the past five years in reducing financial and access barriers to care has been the advent of the SCHIP program. Title V has worked closely with the Medicaid agency in Michigan to develop effective outreach strategies and identify potential eligible women and children. In just over one year, we have already enrolled over 60,000 children of the 106,000 estimated eligible children onto our MIChild program. This has been a very successful relationship and has benefitted many of our State's families significantly.

Key among the enabling services that focuses upon many of the identified state needs to address infant mortality and preterm and low birth weight are services that offer support to pregnant women. We continue to investigate ways to improve our Maternal Support Services program and our Maternal and Infant Health Advocacy Services program. A recent evaluation of the MSS program shows that women involved in these services are more likely to access prenatal care and to practice heathier lifestyles such as reducing smoking. We continue to work with managed care providers to improve the screening

and identification of women in need of MSS services.

As for linkages to promote provision of services and referrals between primary care and specialized care, again, the movement of services into managed care systems has allowed the state to require standards that assure such linkages including assurances regarding the types and availability of providers to whom the population must have access. These contract requirements are confirmed before contracts with managed care organizations are executed.

The data information used to construct the percent of CSHCN who have a medical home consists of CSHCS beneficiaries who are identified as having commercial HMO coverage, and beneficiaries who are enrolled in the CSHCS SHPs. The need for a medical home for children with special health care needs remains significant to assure that all care is appropriately coordinated as well as provided. The need assessed relative to the issue of increasing the number of CSHCS beneficiaries with a medical home is one of increasing the numbers of beneficiaries enrolled in the SHPs. This need is expected to be more adequately addressed as the SHPs expand coverage across the state. There is also a strong need to increase the number of beneficiaries enrolled in the SHPs in order to keep the SHPs a viable alternative which makes the increased number children with special needs having a medical home possible.

The need for identified care coordinators for CSHCS beneficiaries enrolled in the SHPs is being addressed with an 85% success rate, but remains as a need. The goal and contractual requirement is 100%. The large majority of SHP enrollees in the last fiscal year did have an identified care coordinator, but due to implementation difficulties the process was not as comprehensive as it had been predicted to be. Most of the implementation difficulties are expected to be resolved by the next reporting period. As the identification of care coordinators per member occurs regularly for the entire enrolled population, the need will move to increasing the number of SHP enrollees in order to increase the number of CSHCS beneficiaries receiving the benefits of an identified care coordinator. As mentioned earlier, there is also a strong need to increase the number of beneficiaries enrolled in the SHPs in order to keep the SHPs a viable alternative which makes the increased level of care coordination possible.

3.1.2.4 Population-Based Services

Population-Based Services - Public education campaigns
Newborn screening
Newborn hearing screening
Vaccine preventable illnesses
Outreach for Medicaid and Children's Health Insurance Program

There continues to be need for several population based services that are directly administered by the Michigan Department of Community Health. Key among these are newborn screening, lead screening, immunization, reduction of SIDS, access to oral health services and fetal alcohol awareness. We will be focusing particularly on newborn hearing screening, lead screening and immunization. With the evolution of new technologies that allow for newborns to be screened at birth for congenital hearing loss, the ability to intervene and provide services becomes paramount. It is our vision, over the next five years, to achieve the goal of assuring that every newborn in the State of Michigan is screened for congenital hearing loss. As for immunization, Michigan has made much progress in improving the rates of immunization among our preschool population. However, we have still not reached our goal of 90%. At the current time only 79% of this age group is up to date on immunizations. Finally, much work is needed to improve our lead screening rates. We are working with Medicaid to compare data files to better ascertain the numbers of Medicaid children screened for lead. According to our best estimates, less than 50% of this population was screened last year.

3.1.2.5 Infrastructure Building Services

Infrastructure Building Services - Provider education on women's health issues
Improved quality of care for women, infants and children
Increased information on access to appropriate preventive and primary care for children
Preconceptional health planning
Improved information dissemination on prenatal care

access and birth outcomes
Improve the maternal mortality surveillance system
Infant and child death review system
Parent Participation Program
Hourly Nursing Services
Technological Progress in Digital and Programmable Hearing Aids
Improved Information on Type II Diabetes
Access to Dental Services for CSHCN

A very high priority for our state is building epidemiological expertise within our Department that is dedicated to Maternal and Child Health. In the last two years, we have hired two full time epidemiologists and have also secured services of two interns. The Department has created a Bureau of Epidemiology, staff of which work closely with Title V staff to analyze and publish information on our MCH population. In addition, Michigan published its first PRAMS report (1996) and intends to publish data for 1997-1999 soon. We are extremely pleased with the capacity we are building in epidemiology and will continue these efforts over the next five years.

Michigan does a very good job of coordinating Title V related services and activities with other state and federal initiatives focused upon the MCH population. We have several collaborative initiatives with our welfare agency (Family Independence Agency), specifically the “Child Well Being “ program, teen pregnancy reduction efforts, SCHIP, 0 - 3 prevention services, and Child Death Review. We also collaborate with the Department of Education around Early On (Part C), SCHIP outreach, school health, and teen health centers. We are working closely with WIC to improve immunization rates in the WIC population, to outreach SCHIP potential enrollees, and to co-locate WIC and MSS services. We work close with the office of HIV/AIDS prevention as we coordinate our Ryan White Title IV activities with them.

Most of the CSHCS beneficiaries in Michigan have an additional source of insurance for their primary and other specialty care needs either through Medicaid coverage or through a private insurance coverage. Only 9.5% have been identified as having

another source of medical care coverage. We expect to see that percentage impacted somewhat as the Michigan SCHIP program called MIChild increases it's membership. A significant need has been to have the systems ability to identify those CSHCS beneficiaries who also have MIChild coverage. That need has been addressed in a basic manner. Systems modifications are underway to increase the reliability of this data.

Uniquely, eleven years ago, CSHCS established the Parent Participation Program (PPP), a parent-directed unit which ensures that families of diverse cultures help shape CSHCS programs and policies. PPP oversees a community-based parent-to-parent support network of families of children with special needs. The Family Support Network of Michigan (FSN) is a growing statewide network of families and provides a way for families to come together for emotional support, practical suggestions for day-to-day living, and information about services related to CSHCS or to other programs and needs.

In an ongoing collaborative effort, CSHCS and family representatives have developed a process for consumer/community input which has resulted thus far in a number of methods in which consumers are maintained as key players such as:

Community Forums that are held in each county as new managed care options are offered.

Ongoing **Focus Groups** that are convened whenever new changes to program and policy are being considered.

Ongoing **Family Surveys** that are taken at each step of the enrollment process to make sure procedures are working well and policies are responsive to the diverse needs of families.

Trainings for families are provided on: support parent training, sibling issues, fathers network and information is provided on grandparent issues.

Planning is underway to do an evaluation of the FSN network this year.

In addition, the CSHCS advisory committee provides advice and consultation to the CSHCS Plan Division. Membership consists of no more than 16 members, 8 of whom

are parents or guardians of children in CSHCS, or are the spouse of an adult in the CSHCS program.

Michigan has minimal need in this area. Our focus remains constant regarding continuous quality improvement regarding both the development of the CSHCS program to address the needs of the family, and in assuring that we seek effective means by which to garner family input regarding program policy, procedure, and outcome. We have however identified the following areas of need:

SPECIALIZED COMMUNITY-BASED CARE COORDINATION: This is the term CSHCS is using to differentiate care coordination activities and responsibilities for children authorized for CSHCS hourly service benefits (under the Specialized Home Care Program (SHCP) or CHILDS Program) from that of care coordination provided to the broad CSHCS population. At any given time, there are between 225 - 250 children authorized for hourly nursing/aide services. CSHCS has provided care coordination for this group of children/families through 2 different mechanisms:

1) state-employed Specialized Case Managers have provided services to children with the highest level of technology dependencies - typically children who are ventilator dependent; and,

2) members of the CHILDS Team have worked to identify persons in local public health or mental health agencies to provide care coordination/case management services for children authorized for hourly services by the CHILDS Program.

CSHCS is combining the SHCP and CHILDS Program into an hourly nursing benefit, with a single application. Eligibility and level of services authorized will be based upon the needs of the individual/family. Hourly nursing/aide services will be authorized by the CSHCS Plan Division, Program Services Section. To assure a community-based approach to care coordination for beneficiaries authorized for these resource-intensive services, a plan is being developed to identify and train 'Specialized Community-Based Care Coordinators' (SCBCC), and to develop a state-wide network of SCBCC to provide care coordination for beneficiaries enrolled in the CSHCS Fee-For-Service Health Plan. (CSHCS Special Health Plans (SHP) will provide or contract for SCBCC activities for beneficiaries authorized for hourly

services, and who enroll in one of the SHPs.)

The focus for SCBCC is working collaboratively with the family, discharging institutions, the beneficiary's health care providers, and other community-based agencies to develop and implement an individualized plan of home and community-based service supports and health care. This role includes assessing the 'burden' of care imposed by the beneficiary's special health needs, the family's capacity to respond to the beneficiary's care needs, available community resources and supports, and needed medical/health-related services. The SCBCC will assist the beneficiary/family to obtain needed services, and will assess the on-going need and eligibility for special service supports. The SCBCC will also monitor services delivered under the individual service plan, and with modifications of the plan, as appropriate.

HOURLY NURSING SERVICES: Although hourly nursing services can be authorized by the SHCP or CHILDS Program as a CSHCS benefit under a narrowly-constructed definition of medical necessity for licensed nursing care, only MA-enrolled (Medicare certified) home health agencies can be authorized to provide these services. It is becoming increasingly difficult to identify home health agencies willing to accept hourly care cases, and for agencies to adequately staff the cases they do accept. Several factors contribute to this need, including: 1) many Medicare certified home health agencies are responding to the requirements of the Balanced Budget Act by cutting their ties with private duty nursing agencies; 2) although recently raised, certified agencies claim the Medicaid fee-screen for hourly nursing is inadequate; 3) waivers implemented through managed care entities can contract with individual nurses or with private duty agencies for hourly care, paying a rate higher than what would be passed on by a certified agency; 4) in some areas there is fierce economic competition among hospitals, home health agencies, and other employers for the same (relatively scarce) nursing resources; 5) the midnight shift, often needed by families, is the shift most difficult to fill; and 6) the number of licensed nurses, in some geographic areas, is inadequate to the total demand - from all sources - for licensed nurses.

CSHCS is currently reviewing other options related to provision of hourly nursing to determine the risks and benefits of adding 'private duty nursing' as an optional service benefit. Within the next 18 months, CSHCS will also initiate a project in collaboration with home health agencies and other programs within the Department, to explore other strategies for connecting beneficiaries with hourly services supports.

TECHNOLOGICAL PROGRESS RESULTING IN DIGITAL AND PROGRAMMABLE HEARING AIDS: Technology in hearing aids has advanced with the development of the digital and the programmable hearing aids. These new hearing aids provide a significant improvement for many hearing impaired persons. Up until recently, there has not been a clear understanding or criteria of when the change or improvement is significant enough to warrant the increased cost of switching from a traditional hearing aid to a digital or programmable hearing aid. Michigan has developed initial criteria upon which to base these decisions, and will be covering these specific types of hearing aids shortly under certain circumstances. The criteria will be evaluated and revised as additional data upon which to base these decisions becomes available.

TYPE II DIABETES: Historically CSHCS has limited its coverage for diabetes to Type I diabetes. Recently studies tend to suggest that good medical management in Type II diabetes leads to the reduction and delay in the onset of complications just as in Type I. Michigan has also experienced a remarkable increase in the incidence of Type II diabetes in young people, and is considering whether to add Type II diabetes as a CSHCS qualifying diagnosis. The need has been identified for comprehensive data that will provide a basis for determining the efficacy of including type II diabetes as a CSHCS qualifying diagnosis for coverage.

ACCESS TO DENTAL SERVICES: Access to dental services is a need for children with special health care needs. Often this population is harder to serve than the general population due to their extenuating circumstances. CSHCS covers some orthodontia and general dental services when the medical need is related to the CSHCS qualifying diagnosis. Using our current level of formal appeals submitted by families who have been denied coverage for certain dental services as a flag of

potential need by the population, there seems to be a general need for more dental coverage than what is currently available under CSHCS coverage. In addition, families often have difficulty finding dentists or orthodontists who are willing to accept their children for needed and covered services. This population is in need of a larger pool of dentists and orthodontists from whom to receive covered services.

The Department of Community Health has recently implemented a plan to increase the number of providers willing to provide dental services for Michigan's children who have Medicaid coverage through an initiative with Delta Dental. CSHCS is expecting to see some positive impact upon access for CSHCS beneficiaries through this project. In addition, CSHCS is increasing the CSHCS specific fee screen for certain dental/orthodontic procedures, and is removing the requirement for prior authorization for certain procedures in an attempt to increase access for children with special health needs.

OTHER: CSHCS also has the need for current and specific information regarding many health status indicators and CSHCS qualifying conditions such as asthma, universal newborn screening, etc. These will not be discussed further here as the Department has provided that information elsewhere in the document relative to the specific areas of expertise. They are mentioned here only because their findings will impact the CSHCS program regarding practice patterns, increased technological resources, additional children with special health care needs identified as eligible for CSHCS coverage through better identification, as well as through the expansion of the number of qualifying diagnoses.

3.2 Health Status Indicators

See Section V. Supporting Documents, 5.4 Core Health Status Indicator Forms, and 5.6 Developmental Health Status Indicator Forms

3.2.1 Priority Needs

See Section V. Supporting Documents, 5.8 All Other Forms, Form 14

Michigan has identified the following priority needs as a result of completion of the five year needs assessment and analysis by staff and various MCH related program managers. We also received input from local agency representatives. The criteria used to establish priority needs were: availability of data; Healthy People 2010 objectives; trends (rapid increase or decrease); severity of consequences; extent of problem; realistic expectations of program impact; disparity from national average; and acceptability (perceived as a health problem by the public). From this analysis, the following priority needs have been determined for FY 2001 through FY 2005.

Reduce the racial disparity between black and white infant mortality: The racial disparity for infant mortality between the black and white populations continues to be a high priority both in Michigan and nationally. In Michigan, the black infant mortality rate for 1998 was 16.8 and the white rate was 6.3. This compares to 6.3 nationally for whites and 14.6 for blacks in 1995. The 2010 objective is to reduce the infant mortality rate to no more than 5 per thousand live births. Michigan is at 8.2 in 1998.

Reduce the numbers of maternal deaths in the black population: Michigan experiences one of the largest disparities in the nation between maternal deaths among its black and white populations. We have recently put much effort into revamping our maternal mortality review process so we can better learn the nature and causes of each death that occurs and analyze possible prevention strategies.

Reduce the percent of preterm births and births with low birth weight with emphasis on the black population: Michigan still experience rates of births with low birth weight well above the national average (7.9 percent as compared to 7.3%) In addition, the rate has increased slightly between 1995 and 1998 from 7.7% to 7.9%. At the same time, the low birth weight percentage for blacks is double that for whites (13.9% compared to 6.5%) Renewed efforts are needed to determine effective interventions both preconceptionally and prenatally that can improve these statistics. Over the next five years, MDCH anticipates putting significant effort into linking various data bases and evaluating the impacts of specific interventions in an attempt to determine the most effective strategies to reduce infant mortality generally and low birth weight specifically.

Reduce the percentage of unintended and teen pregnancies with emphasis on repeat live births to unwed teen mothers: While Michigan experiences slightly lower rates for unintended pregnancy than that experienced nationally (43.2% in 1997 compared to 49% nationally), the objective for 2010 is to decrease this rate to no more than 30%. Additionally, among women who experienced an unintended pregnancy, our PRAMS data shows that 68.7 percent were Medicaid recipients at some time during their pregnancy. This calls for renewed effort to address access and barriers to care issues for women in this population. The teen pregnancy rate for Michigan is 71.6 per thousand in 1998 compared to 120 nationally. While we have seen progress in this area, it is still a high priority for the public in our state and for this administration. A significant amount of the bonus funds (total of $20 million) that Michigan received for reducing out of wedlock births between 1995 and 1997 will be targeted toward reducing teen pregnancy rates in targeted jurisdictions within Michigan that reflect historically high teen pregnancy rates. In Michigan during 1998, 21.3 percent of teens who had previously given birth had a repeat birth.

Establish a medical home and increase care coordination for children with special health care needs through managed care service delivery systems: Children with special health care needs (CSHCN) have complex medical problems that require care and services from multiple providers who are frequently not located in close proximity. More importantly, there is oftentimes a lack of communication between providers and no focal location for accumulation of comprehensive medical care and treatment records for these children. This is of great concern as medically fragile CSHCN are already at significant health risk because their medical conditions may fail to improve, or even deteriorate. Special Health Plans (SHPs) designed to deliver managed care to the Michigan CSHCS population can provide a medical home where all care and services are coordinated through the development of an Individualized Health Care Plan (IHCP) for each beneficiary. A local care coordinator and principal coordinating physician offer a coordinated approach for all medical services for CSHCN. With statewide expansion of SHP coverage in Michigan, a true medical home will be available to all persons who enroll in a CSHCS Special Health Plan, with the goal of improving quality of care.

Improve and assure appropriate access to health services, including oral health services, that are focused on children with special health care needs: CSHCN

frequently have primary medical conditions, such as cleft lip and palate, that are eligible for CSHCS coverage of extensive and complex dental services, or have diagnoses that require use of general anesthesia during routine dental care and treatment of dental problems. Identification of qualified dentists who have the necessary equipment and access to facilities to perform these services are limited. Dental providers have also complained about low reimbursement rates, convoluted billing processes and prior authorization requirements for some services. In Michigan, we are actively making changes to appropriately increase dental reimbursement, remove some prior authorization and recruit dentists willing to serve the CSHCN population. These recent efforts are expected to increase access to dental care for the CSHCN population.

Improve the capacity for newborn hearing screening and assure communications with appropriate systems of follow up when indicated: There has been significant progress made in the technology that allows for effective screening of newborns for hearing loss. In Michigan, we have been working diligently to engage hospitals to voluntarily screen newborns for hearing loss. However, to date, only 61% of the total newborn population is receiving an objective hearing screen in 54 of the 120 birthing hospitals. Additionally, only 50% of the infants who failed the initial screen during the current year received further evaluation and follow-up. This new technology offers public health a new tool in our arsenal to detect and prevent significant hearing loss and development problems in our pediatric population, and we have a public obligation to take advantage of this opportunity.

Increase the screening rate of low income children for lead poisoning: Michigan residents are exposed to varying amounts of lead in their environment from sources such as lead-based paint, dust, soil, food, and water. The exposures are cumulative in children, especially those under six years of age, because they are more vulnerable to the toxic effects of lead and show greater effects upon the blood-forming and central nervous systems. Children living in poverty are most at risk. In 1999, it was estimated that approximately 183,000 children ages 0 - 4 resided in households with incomes below 125% of poverty. In that same year, lead screening was reported on 77,434 children below age 6. This means that less than 42 percent of children at risk of lead exposure were screened for lead poisoning. Of the 77,434 children screened, 5,467 (7%) had levels greater than 10 micrograms per deciliter. Because of 1) the existence of significant numbers of old houses

in Michigan, 2) the fact that the percentages of children living in poverty are increasing, and 3) there are medical and public health interventions that are available to prevent and lower blood lead levels in children identified with elevated lead levels, this is a public health priority in Michigan.

Increase the rates of breast-feeding: In 1998, the rate of breast-feeding in early postpartum was 44% among Michigan WIC clients as compared to 59% in Michigan and 64% nationally. There is a large difference in breast-feeding rates between black (32%) and white (48%) WIC mothers in Michigan. This difference also persists nationally with a breast-feeding initiation rate of 45% among black mothers as compared to 68% among white mothers. The prevalence of breast-feeding at 6 months of age was 16% for the WIC mothers compared to 25% in Michigan and 29% nationally. There has been a steady increase in both initiation and duration of breast-feeding since 1990 at all levels with the largest climb among mothers who receive WIC benefits. From 1990 to 1998 there has been a 33% increase in the initiation rate and a 50% rise in the proportion of mothers who breast-feed their infant at 6 months of age among the Michigan WIC clients. The Healthy People 2010 target is to increase the rate of mothers who initiate breast-feeding to 75% and the rate at 6 months to 50%. With the many reported benefits, increasing the breast-feeding initiation and duration rates in Michigan will have a positive impact on the health status of Michigan infants. The promotion and protection of breast-feeding among Michigan WIC eligible and black mothers is an even more important public health goal.

Reduce the rates of childhood injury: Injuries stand out as the leading cause of death for children and youth in Michigan, as well as the nation. Every year, approximately 240 Michigan children aged 1-14 years die as a result of injuries due to preventable motor vehicle crashes, falls, fires, drowning, bicycle crashes and poisoning. An additional 55 deaths in this age group were intentional (approximately 40 homicide and 15 suicide). In addition, thousands of children are hospitalized or seen in emergency rooms each year as a result of injuries. Because injuries impact children and young adults, they account for more years of potential life lost than for other health conditions. In fact, each year, more children over one year old die from injuries than from all childhood diseases, birth defects and chronic conditions combined. There are a variety of engineering, educational and policy interventions that have been proven to reduce injuries and fatalities and there is a need to

implement these strategies throughout the state. If Michigan did as well as the average of the top six states in injury prevention for just six categories of preventable injuries - fire, drowning, suffocation, pedestrian, bicycle, and motor vehicle - the lives of 164 children would be saved each year and 7,380 hospitalizations for injuries would be prevented.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of the Budget Forms

See Section V. Supporting Documents, 5.8 All Other Forms, Forms 2, 3, 4, and 5

3.3.2 Other Requirements

In FY '89, the maintenance of effort amount was $13,507,900. This amount represented state funds spent for Children with Special Health Care Needs, family planning, adolescent health, local MCH programs, and WIC.

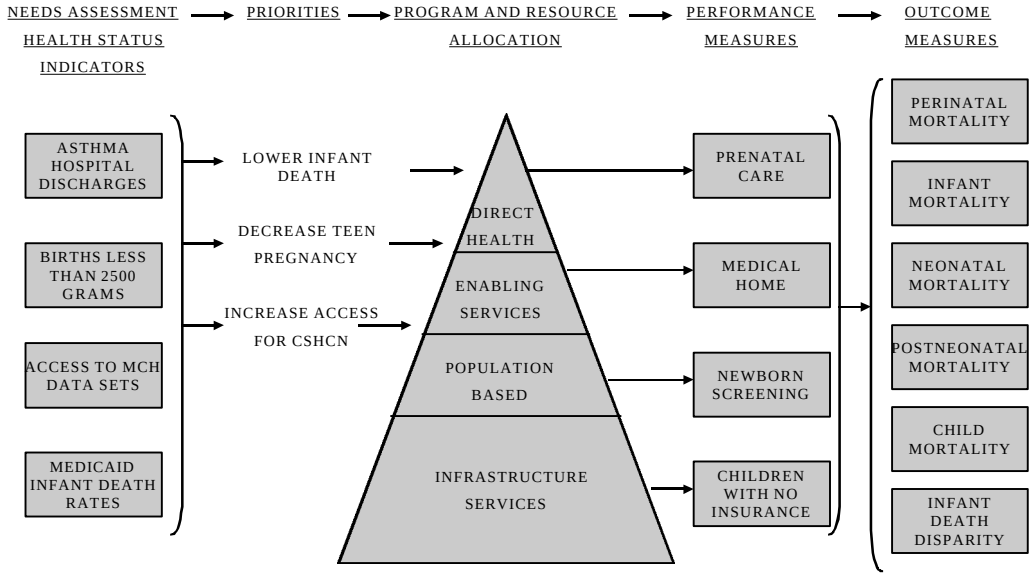
The projected match (including overmatch) for FY '01 is $37,130,300. In addition to state general fund monies, the federal-state block grant partnership includes program income from the WIC, newborn screening and CSHCS programs, and Children's Trust Fund monies supporting the CSHCS program.

There are no significant budget variations from 1999 to 2001.

3.4 Performance Measures

Figure 3

TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM



3.4.1 National "Core" Five Year Performance Measures

FIGURE 4

PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breast-feed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) Percent of very low birth weight live births.				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

3.4.1.1 Five Year Performance Objectives

See Section V. Supporting Documents, 5.8 All Other Forms, Form 11

3.4.2 State "Negotiated" Five Year Performance Measures

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
10. Infant mortality rate of live births	X					X	
11. Maternal mortality ratio in black women.				X			X
12. Percent of low birth weight births (<2500 grams) among live births.		X					X
13. Percent of preterm births (<37 weeks) among live births.		X					X
14. Percent of live births resulting from unintended pregnancies.			X				X
15. Percent of repeat live births to unwed mothers 15-19 years of age.			X				X
16. Percent of CSHCS beneficiaries enrolled in a managed care Special Health Plan.				X		X	
17. Utilization of dental services by CSHCS beneficiaries (CSHCS reimbursed).	X					X	
18. Percent of Medicaid enrolled children 0-6 years of age who receive lead screening.	X					X	

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.1 Development of State Performance Measures

See Section V. Supporting Documents, 5.10 State “Negotiated” Performance Measures Detail Sheets

3.4.2.2 Discussion of State Performance Measures

Infant morality and the disparity between the white and black IM rates, in particular,

remains a priority concern of public health in Michigan, along with the contributing measures of low birth weight, preterm births, unintended pregnancy and teen pregnancy. As the needs assessment indicates, many of these indicators are higher in Michigan than national rates and some, in recent years, are going in the wrong direction. The negotiated performance measures selected represent areas where special effort is needed to effect change, in addition to the core performance measures.

Most of the negotiated performance measures have a direct correlation to the state's priority needs. The following chart shows the relationship between the negotiated performance measures and the state's priority needs and outcome measures.

Negotiated Performance Measures	**Priority Needs**	**Outcome Measures**
Infant mortality rate of live births	Reduce racial disparity between black and white IM	Infant mortality rate; ratio of black IM rate to white IM rate; neonatal mortality rate; postneonatal mortality rate; perinatal mortality rate
Maternal mortality ratio in black women	Reduce number of maternal deaths in the black population	
% of LBW births among live births	Reduce the % of preterm and births with LBW with emphasis on the black population	Infant mortality rate; ratio of black IM rate to white IM rate; neonatal mortality rate; perinatal mortality rate
% of preterm births among live births	Reduce the % of preterm and births with LBW with emphasis on the black population	Infant mortality rate; ratio of black IM rate to white IM rate; neonatal mortality rate; perinatal mortality rate

% of live births resulting from unintended pregnancies	Reduce the % of unintended and teen pregnancies with emphasis on repeat live births to unwed teen mothers	Infant mortality rate; ratio of black IM rate to white IM rate; neonatal mortality rate; postneonatal mortality rate; perinatal mortality rate
% of repeat live births to unwed mothers 15-19 years of age	Reduce the % of unintended and teen pregnancies with emphasis on repeat live births to unwed teen mothers	Infant mortality rate; ratio of black IM rate to white IM rate; neonatal mortality rate; postneonatal mortality rate; perinatal mortality rate
% of CSHCS beneficiaries enrolled in a managed care Special Health Plan	Establish a medical home and increase care coordination for CSHCN through managed care service delivery systems; Improve and assure appropriate access to health services, including oral health services, that are focused on CSHCN.	
Utilization of dental services by CSHCS beneficiaries	Improve and assure appropriate access to health services, including oral health services, that are focused on CSHCN	
% of MA-enrolled children 0-6 years of age who receive lead screening	Increase the screening rate of low income children for lead poisoning	

The programs and activities to be carried out related to each of the performance

measures span several levels of the pyramid. For purposes of classification, judgements were made based on the proposed activities and special initiatives indicated in the annual plan. Programs and activities designed to effect infant mortality, low birth weight, and preterm births include components that fall into all four levels of the pyramid. However, the focus will be on assisting women to access appropriate services on a timely basis. The focus for maternal mortality will be to improve our surveillance system so that we have a better understanding of the issues. Strategies to prevent unintended pregnancies and repeat live births to unwed mothers 15-19 will focus on outreach to this population to get them into appropriate services. Strategies for SP 16, 17 and 18 will concentrate on increasing utilization of services.

3.4.2.3 Five Year Performance Targets

See Section V. Supporting Documents, 5.8 All Other Forms, Form 11

3.4.2.4 Review of State Performance Measures

3.4.3 Outcome Measures

See Section V. Supporting Documents, 5.8 All Other Forms, Form 12

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

- Direct Care

Pregnant Women, Mothers and Infants

The direct care services programs that target pregnant women, mothers and infants all promote access to services, educate the target population and the general population about the need for preventive and primary health care, protective behavioral health

education and non-medical support services. The programs that address the population's needs are:

Prenatal Care Outreach and Advocacy
Prenatal Care Demonstration
Michigan Local MCH Block Grant (includes requirements to address local MCH needs identified by the local community needs assessment)
Family Planning Services (includes related services such as STD treatment and HIV/AIDS client center counseling, special focuses on women with substance abuse issues and underserved populations)
Prenatal Smoking Cessation
Maternal HIV/AIDS Support services
Maternal Support and Infant Support Services
Maternal and Infant Health Advocacy Services
Newborn Screening
Newborn Hearing Screening
Immunization
WIC

The Title V agency's role is one of support, leadership, collaboration and coordination to assure state of the art, community specific, culturally sensitive, and gender specific services are developed and delivered. While the agency specifically focuses on the high risk population, the MCH population is always of general consideration. Our objectives demonstrate our general population. Targets are, for example, we will reduce infant mortality, not just the infant mortality for the low income population.

Related to Priority Need # : 1, 2, 3, 4, 7, 9
Related to Performance Measure(s): # 4, 5, 9, 10, 12, 13, 15, 17, 18, SP 10, SP 12, SP 13, SP 14, SP 15

Preventive and Primary Care Services for Children

Our focus is services not provided in the general health care arena for specific health

care issues of children. Primary health care for children is more readily available, so direct services in the public health arena are not as numerous as those for pregnant women and infants. Direct services programs include: Childhood Lead Poisoning Prevention, Adolescent Health Centers and Alternative models, Fetal Alcohol Syndrome Prevention, Oral Health, Vision and Hearing Screening, Bicycle Helmet and Safety Seat, MCH HIV/AIDS and Michigan Abstinence Partnership.

Related to Priority Need # : 4, 8, 10
Related to Performance Measure(s): #5, 6, 7, 8, 16, SP 13, SP 14, SP 18

Services for Children with Special Health Care Needs

All children in Michigan who receive SSI coverage, are also eligible for Medicaid coverage, and are therefore, entitled to needed rehabilitative services through that coverage. Some of those children are also eligible for and are covered by CSHCS due to a medically eligible diagnosis. Current activities to ensure that children with SSI also receive Medicaid coverage are appropriate and adequate to meet this population's rehabilitative service needs. Currently, outreach activities are conducted to identify children who may also be CSHCS eligible. No additional activities are planned to include more of the children with SSI coverage in the CSHCS program than those currently in place, as Medicaid addresses most, if not all, of the rehabilitative services required of the majority of the SSI population. The annual target has already been met.

CSHCS currently reimburses on a fee-for-service basis for all covered specialty and subspecialty services related to each participating beneficiary's qualifying condition(s) which is otherwise inaccessible or unaffordable to the individual or family. Children in the fee-for-service delivery system receive care coordination when a need for the service is authorized by the CSHCS program on a case-by-case basis. The total number of children receiving comprehensive care coordination has increased secondary to enrollments into the Special Health Plans (SHP) because the SHP contractors are required to provide care coordination to all members. The only additional activity to increase the number of children receiving care coordination is the growth and expansion of the SHPs. The annual target is to increase the number of children receiving care

coordination through increased voluntary enrollment into CSHCS SHPs. The Special Health Plans are required to provide care coordinators for all children enrolled in their health plan.

The Individualized Health Care Plan (IHCP) is a comprehensive plan of care developed for all beneficiaries who enroll in a CSHCS Special Health Plan. Once enrolled in a SHP, a Principle Coordinating Physician (PCP) is identified and required to participate in the development of the IHCP in conjunction with the family and other providers to establish a comprehensive document regarding each child's health, social, emotional, and educational needs. Services and providers identified in the IHCP do not require further approval.

The plan for meeting the performance measure is to contractually require and monitor the development of an IHCP for each SHP enrollee. The percentage of beneficiaries receiving an IHCP will depend upon how many choose to enroll into a SHP. Activities will include education and encouragement for families to enroll their CSHCS eligible children into SHPs based on additional benefits provided by the SHPs including the IHCP, which is only available for children enrolled in a CSHCS Special Health Plan.

Related to Priority Need: # 5, 6
Related to Performance Measure(s): #1, 2, SP#07

- Enabling Services

Pregnant Women, Mothers and Infants

Services to reduce barriers to accessing care and support services are needed for populations with cultural, financial and educational disincentives to using mainstream health care services. Great strides have been made in removing financial barriers. Several years ago Michigan declared prenatal care a basic health service. This means that all Michigan residents have a right to prenatal care regardless of ability to pay. Since allowed, Medicaid eligibility criteria have been expanded to allow pregnant women and infants coverage up to 185% of poverty. Promoting the expanded Medicaid

eligibility for the group is still an ongoing effort. Local health departments have been accountable for outreaching and assisting women to enroll in Medicaid and for accessing prenatal care and follow-up care for their infants. This responsibility will continue with the local health departments and federally qualified primary care centers have been supported to provide this outreach and support as well. This responsibility has been expanded to children, as outreach efforts will be needed for children to get them enrolled into appropriate programs (including Medicaid) to reduce the financial barriers to preventive and primary care.

Along with promoting the awareness of expanded Medicaid eligibility criteria, there is a continuing need to educate Medicaid clients about using the managed care system in which they must now receive their care. The Department is addressing this need by developing a service to assist clients to understand how to use the system and to select a health care provider from among the choices available in their area.

Most of the state has moved to a managed care delivery system. A few counties, because of circumstances, many not be moving to managed care because of the unavailability of managed care providers. One of the issues we are closely monitoring is the ability of pregnant women to access early prenatal care within the managed care delivery system.

Addressing the disparity of the difference in the black and white infant mortality rates requires some additional attention. The state confronts this by focusing and concentrating existing infant mortality efforts in communities with higher African American population. To speak to the cultural competence, each community develops and operates their programs to suit their target population within the guidelines offered.

Since 1991 Michigan has had a Perinatal Hepatitis B Prevention program to identify pregnant women who are chronically infected. The infants of these women receive the first dose of hepatitis B vaccine and a dose of hepatitis immuneglobin very soon after birth.

Another program for improving children's health care access is Michigan's Child Health

Insurance Program, MIChild. This federally funded initiative will significantly reduce financial barriers for children up to 200% of poverty. The insurance coverage is approximately equivalent to the liberal state employees' health benefits.

MCH HIV/AIDS (Title IV) program provides family centered case management services for the population. A significant portion of this service time is assuring access to care and assisting population members to remove barriers to care.

Maternal and Infant Health Advocacy Services provide peer support services to pregnant women who at risk of not staying in prenatal care or infants who are at risk of not accessing and staying in primary and preventive health care.

Related to Priority Need # : 1, 4
Related to Performance Measure(s): # 12, 13, 15, 17, 18, SP 10, SP 12, SP 13, SP 14, SP 15

Preventive and Primary Care Services for Children

Enabling services for children include: movement to the managed health care system for direct services, Health Systems Development in Child Care, Immunization and Immunization Liaison, Maternal and Child HIV/AIDS, Local MCH Block grant which includes Medicaid outreach and *Early On*. Developing and maintaining support systems for families to become aware and access health care services is vital for those with limited resources. Transportation, child care, translation, case management and advocacy services all promote assistance and trust to empower families. Also, note the description of the MIChild program above.

Related to Priority Need # : 4, 8
Related to Performance Measure(s): #5, 12, 13, SP 14, SP 18

Services for Children with Special Health Care Needs

Michigan has implemented and is now expanding the CSHCS Special Health Plans

(SHP) which provide access to a recognized medical home for children with CSHCS coverage who voluntarily enroll in a SHP. The medical home provides a single location for coordination and support of the child's treatment plan. The Principle Coordinating Physician (PCP) is responsible for providing a central repository of the entire array of medical services for the child and assuring coordination of services. This allows for better coordination and decision making to occur. The SHP contract has established requirements related to the medical home definition and function designed specifically to address the special needs of children with special health care needs and their families.

Extensive effort is directed toward outreach and education activities of the State enrollment services contractor staff of MICHIGAN ENROLLS. These activities are for the purpose of better preparing the contractor and affiliated agencies to educate and assist families in making an informed decision regarding selection of a CSHCS Health Plan. (Choices include one or both Special Health Plan or the traditional "Fee-For-Service" Plan).

Enrollment into CSHCS Special Health Plans is voluntary. Families are contacted by the enrollment services contractor (MICHIGAN ENROLLS) to choose a CSHCS Health Plan for delivery of covered services either through the fee-for-service health plan, or one of the Special Health Plans. Enrollment into the SHPs is increasing and expected to continue over time, thereby also increasing access to an identified medical home. The Fee-For-Service plan and the SHPs are closely monitored for the need to adjust policies and procedures that will increase access and desire for enrollment into the SHPs, which are in turn increasing the number of children in the CSHCS program who have an identified medical home.

Some children receiving CSHCS coverage through the Fee-For-Service plan are eligible for care coordination under specific criteria. Care coordination is required for all members who are enrolled in a SHP. Therefore, more CSHCS beneficiaries are receiving care coordination services through enrollment with a SHP than are eligible through the Fee-For-Service plan.

The plan for increasing the number of children with special needs receiving care

coordination requires increasing the numbers of children with CSHCS coverage who receive those services through a Special Health Plan. Activities include monitoring the use of care coordination within the SHP to ensure that the numbers of children receiving care coordination services increases. The percentage of children receiving care coordination depends upon how many children enroll with a SHP. Activities include the education and encouragement of families with children who are eligible for CSHCS to enroll into Special Health Plans.

Related to Priority Need: #5
Related to Performance Measure(s): #3, SP #04

- Population Based Services

Pregnant Women, Mothers and Infants

Our most widespread population-based service is outreach. First and foremost is the task of identifying the population to be served and then using the enabling services to promote accessing health care services. Population-based services to this population consist of Michigan's Prenatal Outreach and Advocacy Services, Medicaid Outreach to promote EPSDT screens for all eligible kids, Immunization, Childhood Lead Screening Surveillance, Fetal Infant Mortality Review, *Early On*, SIDS Education and Surveillance, Newborn Screening and Newborn Hearing Screening surveillance and surveillance of HIV/AIDS in the MCH population.

Related to Priority Need # : 1, 3, 4, 7, 9
Related to Performance Measure(s): # 4, 5, 10, 12, 13, 18, SP 10, SP 12, SP 13, SP 14, SP 15

Preventive and Primary Care Services for Children

Programs that promote preventive and primary care for all children are: Michigan Abstinence Partnership, Oral Mouth Rinse Program, Hearing and Vision Screening Services, Bicycle Helmet Safety, Childhood Lead Poisoning, Immunization, Adolescent

Health Centers and alternative models, Physical Fitness, Newborn Screening, Newborn Hearing Screening and Violence Prevention Promotion. Many of these services address health issues that are necessarily more prevalent in children of low income status. These are also services that are addressed on a population basis and also improve the identification of children in need.

Related to Priority Need # : 4, 8
Related to Performance Measure(s): # 5, 6, 7, 8, 13, SP 14, SP 18

Services for Children with Special Health Care Needs

No activities

- Infrastructure Building Services

Pregnant Women, Mothers and Infants

Local health departments' delivery of MCH direct health care services has dwindled. Most services are provided in the private sector marketplace. This trend will continue with potentially a few exceptions in very rural areas of the state that cannot support a private health care provider. The Title V agency's role has begun to modify in response to this changing trend. More effort and emphasis is being placed on helping local public health providers negotiate contractual agreements with the managed care providers. This will support financial reimbursement for services that are provided. Two major programs where this effort is occurring is in family planning and adolescent health centers.

Being able to measure the affects of our efforts and continue to identify needs of the population requires data. We are meeting this need with the continuation of the Pregnancy Risk Assessment Monitoring Survey. Developing Fetal Infant Mortality Review Teams will provide information on the causes of fetal loss and infant mortality. The effort to restructure the Maternal Mortality Review process will contribute to the State's data needs as well. Newborn hearing screening follow up system is under

development to assure infants who fail their hearing screen are assessed and under care by six months of age.

Related to Priority Need # : 2, 7
Related to Performance Measure(s): # 5, 6, 10, 12, 13, 18, SP 11, SP 14

Preventive and Primary Care Services for Children

In the last survey, Michigan had a representative sample of adolescents in the Youth Risk Behavior Survey. The survey is conducted every two years. The second survey, which is also representative of the population, offers a comparison for change. The last survey established a baseline measure for violence, sex, substance use, and intentional and unintentional injury for adolescents. It also gave information on key health events in adolescents' lives. Through the coalition building in the Michigan Abstinence Partnership, communities develop and plan strategies to promote healthy behaviors among their youths.

The state has a need for better segmentation of families with children by income. We need this for outreach efforts for the Healthy Kids (Medicaid) and MIChild (CHIP) programs. It will also be of significant help to identify the community when other income-sensitive programming can be targeted. Low income is a frequent risk factor for poor health indicators.

To promote quality health care services, Michigan's infrastructure efforts will need to continue focusing on advancing guidance for care, such as the American Medical Association Guidelines for Adolescent Preventive Services or CDC Guidelines for Childhood Lead Poisoning Prevention. We will be looking for additional tools and guidance to address health concerns in children, such as smoking cessation, violence, suicide and HIV infection.

Several efforts will provide needed data to plan for appropriate services and strategies. The Child Death Review teams are nearly statewide and a push to establish Fetal Infant Mortality Review teams are underway. Michigan currently has four local teams with

anticipation of starting an additional six more by the end of FY 99. The Childhood Lead Poisoning Prevention program's administrative rules have been put in place to require all blood lead tests performed in the state and on state residents to be reported. This enables the surveillance of blood lead poisoning. A significant increase in the number of blood test results has vastly improved the surveillance system's development.

Related to Priority Need # : 1, 8, 10
Related to Performance Measure(s): # 5, 6, 7, 12, 13, 16, SP 14, SP 18

Services for Children with Special Health Care Needs

Currently, 90.5% of Michigan children enrolled in CSHCN have Medicaid coverage or some other form of insurance coverage. Children without other insurance who have a family income below 200% of poverty may also be eligible for the Michigan SCHIP program called MIChild. The combination of specialty coverage by CSHCS and MIChild benefits provides a full package of primary and specialty care for children with special needs.

Family participation has been and continues to be a main feature in the development of the CSHCS program, and implementation of the contractual requirements for the Special Health Plans. Michigan's Parent Participation Program (PPP) is an established resource which allows a large and ever changing representation and participation of families with children and adults in the CSHCS program who have special needs. Activities include participation on various advisory committees, review and guidance on policy development, and collaboration in the writing of the Request for Proposals distributed for selection of the SHP contractors. Families have been involved in the SHP readiness reviews conducted of the contractors, will be involved in the on-going site visits, and continue to be involved in the expansion of the SHPs.

Related to Priority Need: #5, 6
Related to Performance Measure(s): #11, 14

4.2 Other Program Activities

The Department of Community Health provides a toll-free hotline for pregnant women (1-800-26-BIRTH and 961-BABY in Detroit-Metro area) and for children with special health care needs (1-800-359-DSCC; T.D.D. #1-800-788-7889). 1-800-26-BIRTH is the primary source of information about health care services available under Titles V and XIX and WIC. This line includes information on immunizations and referral to local health departments and other providers for service. All numbers are coordinated interdepartmentally both at the state and local level.

1-800-26-BIRTH is staffed by health or social service professionals to answer both information as well as crisis calls of pregnant women and parents. The staff are updated, quarterly, on the availability of services, eligibility requirements, and contact persons for local prenatal care and WIC providers and assist the client in identifying these and other providers in the client's community. Counselors are trained to respond to a broad range of health care needs. The hotline is marketed by local and state agencies through pamphlets, posters and public service announcements. Several times a year a flyer describing this service is mailed with every Medicaid identification card to each recipient and in AFDC warrants. In FY 1998-99, 26,685 calls were handled by the statewide and Detroit area hotline.

The Children's Special Health Care Services Family Phone line provides families with a toll free number to communicate with CSHCS staff (at state and local levels), other agencies serving children with special needs (e.g.,genetics counseling centers, local mental health, special education), providers and other families. The Family Phone Line can be used to: obtain general information about CSHCS, contact the Family Support Network, resolve problems related to CSHCS, and contact the Michigan SIDS Center for support services or information. The line is publicized at local parent group meetings and at CSHCS presentations throughout the state. In addition, this number is used to refer families to local health departments and the number is included in the Family Support Network brochure. Family Phone Line calls are responded to within 24 hours and are individually reviewed by the Parent Participation Program with a written confirmation sent to the caller. Family Phone Line calls are compiled and analyzed quarterly to determine areas of special concern to families and to identify needed policy or procedural changes.

With the statewide implementation of Medicaid managed care in 1998, EPSDT services were integrated into the qualified health plans. Most local health departments no longer provide

EPSDT services. The MCH program continues to work with the Medical Services Administration to develop standards of performance and quality for the plans and provides technical consultation. The MCH program also provides training for QHPs and local health departments on the hearing and vision components of EPSDT.

CLCF and CSHCS collaborate on issues regarding follow-up on newborn screening, birth defects registry, newborn hearing screening, hearing screening for school-age children, maternal and infant HIV/AIDS, and children's mental health. Both programs participate on the Department's Developmental Disabilities Council and coordinate policy and program efforts for SSI-eligible children and children and families requiring hourly in-home care.

WIC continues to be an important component of strategies to improve the health of pregnant women, mothers and children. WIC clinics routinely make referrals for lead screening, maternal and infant support services, and prenatal smoking cessation. The clinics also routinely check immunization status and either refer or provide immunizations on site. Outreach activities are coordinated through the MCH hotline. See also Section 1.5.2.

Availability and accessibility of family planning services is a key strategy for reducing unintended pregnancy and teen pregnancy. Resources of Title X, Preventive Block Grant and state funds are combined to assure that women and men in need of family planning services have access to them through a provider of their choosing and through referral arrangements with prenatal care providers, WIC and substance abuse programs. Family planning services are a required component of capitated funding for Medicaid enrollees in qualified health plans. The QHPS are also required to reimburse other publicly funded family planning clinics for family planning services provided to any QHP enrollee. The Division of Family and Community Health provides continuing education and training to Title X family planning clinics and managed care providers. See also Section 1.5.1.2.

There are currently five Healthy Start programs in Michigan. The department initiated a collaborative network of all programs to share their experiences, discuss issues of mutual concern and interest, and to develop standardized evaluation criteria for the programs. The network meets approximately four times a year. The department also assists proposed new programs with their applications by providing data and technical assistance.

The implementation of Medicaid managed care has significantly changed the role of local health departments and the MCH program in assuring access to prenatal care. Qualified health plans are held accountable by contract for providing prenatal services in accordance with standards set by the Medicaid program. A separate organization is contracted to conduct enrollment activities. The Medical Services Administration is responsible for administering the managed care contracts, establishing performance standards, monitoring and evaluating performance. MSA contracts with the Michigan Peer Review Organization to conduct annual performance reviews of all plans. Many local health departments (LHDs) and community agencies continue to provide enrollment and outreach services to low-income women either through agreement with the QHP(s) in their area or with their own resources. Several have had to limit their activity due to funding constraints by reducing staff dedicated solely to enrollment and outreach or by concentrating on the non-Medicaid eligible low-income population. Recently, additional funding was made available by MDCH to local health departments to enroll families, pregnant women and children in Medicaid and MIChild. Local health departments are encouraged to partner with community agencies to extend the scope of this effort. Several community agencies have historically provided outreach and enrollment services and have indicated that they will continue to do so as long as they can find resources.

4.3 Public Input

Formal notice of the Title V application development and public comment process was provided to citizens of Michigan via publication of a notice in three major newspapers covering the entire state. Copies of the draft application were sent to all local health departments, other local contractors, CLCF Advisory Committee, CSHCS Advisory Committee, Family Planning Advisory Committee, and other bureaus within the department.

4.4 Technical Assistance

See Section V. Supporting Documents, 5.8 All Other Forms, Form 15

V. Supporting Documents

5.1 Glossary

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year's MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - ***(For budgetary purposes)*** Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. ***(For planning and systems development)*** Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians,

registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. *[Title V, Sec. 501 (b)(2)]*

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

1) What is essential in terms of the provision of health services;
2) What is available, and
3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also

"Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved,

when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

5.2 Assurance and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited

to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; © Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (I) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable

construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; © protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176© of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sects. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the

Single Audit Act of 1984.

18 Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
© are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled “Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions” in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about-

  (1) The dangers of drug abuse in the workplace;

  (2) The grantee's policy of maintaining a drug-free workplace,

  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and

  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

© Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-

  (1) Abide by the terms of the statement; and

  (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-

  (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or

  (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation

of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress,

an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment;

service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.